

Special Report

By:

Harry S. Dent, Jr.

Author of

The Next Great Bubble Boom

The Roaring 2000s

The Great Boom Ahead

Charles Sizemore, CFA

Research Analyst

Compiled and Edited By:

Rodney Johnson

President

HS Dent Publishing

Table of Contents

Healthcare Adds An Unquantifiable Risk to your Future 2

The Demographics of Healthcare 4

The Healthcare Wave and the Onslaught of Demand 5

Where Are all of the Health Dollars Going? 6

Medicare 7

Paved with Good Intentions 8

Moral Hazard at the Doctor's Office I-1

The Mechanics of Moral Hazard I-2

The "Nuclear Option" I-4

Is My Employer Ripping Me Off? The Problems with Company Insurance Plans 9

The Poor, The Sick, and The Uninsured 12

The Future of Medicine? 14

McDoctor 15

Healthcare: A System at the Breaking Point

Who Is Going To Pay for Your Healthcare in the Years To Come?

There is a something of a consensus among health policy experts ...that the US health care system represents a prime example of the wrong way to organize and finance a health-care delivery system.

—Ohsfeldt and Schneider, from *The Business of Health*

Every single person in America is impacted by the way healthcare is delivered and paid for. It does not matter whether you are young, old, rich, poor, working, or retired; you are part of the system of receiving and/or paying for the benefits. Accordingly, few issues have sparked as much debate among Americans over the past decade as the cost of healthcare and how it is distributed. And while the Ohsfeldt and Schneider quote above may or may not be fair, it is certainly an accurate reflection of popular opinion on the matter. So, is the system really broken? Is our health being compromised to pad the profits of doctors, insurance companies, and Big Pharma? Or are we simply paying higher costs for better treatments that lengthen and improve our lives?

This issue is reaching the boiling point now because of several forces that have been gathering momentum:

- healthcare costs have been marching higher at more than twice the rate of inflation in recent years,
- employers are passing on more of the cost to employees (if they have coverage at all) because of increased competition,
- the largest generation in our economy, the Baby Boomers, is reaching the age at which they will use, or consume, the most healthcare, and
- Medicare, the provider of healthcare to retirees, is already operating at a deficit.

This report focuses on the potential impact of the demographic shift that is already underway as Baby Boomers move to their next stage in life. With the coming retirement of the largest generation in history, concerns about our healthcare system are no longer academic. Healthcare spending increases with age, and the frontline members of the Boomers are already in their 60s. As the wealthiest and most successful generation in history, the Baby Boomers, unfortunately, also are

susceptible to “diseases of affluence,” such as high blood pressure, heart disease, and adult-onset diabetes, which should make this generation far more expensive than previous generations, even on a per capita basis. So the largest generation in history will also be the most expensive *per person*. Suffice it to say, the demands on our health system will increase going forward. This makes a good understanding of the relevant issues all the more crucial.

The unique health concerns of this generation will affect not only the 80+ million Boomers themselves, but also all 300 million Americans and all health-care consumers worldwide. Closer to home, the availability and cost of healthcare will directly affect you and your family.

Healthcare Adds An Unquantifiable Risk to Your Future

We humans are fragile creatures, and keeping our complex bodies alive and healthy in old age or after a significant injury or disease is no easy matter. It's also not cheap. Common diseases such as cancer often require medical treatments that can cost millions of dollars, and this does not include lost wages. Likewise, a serious auto accident can wipe out the finances of even an affluent, upper-middle-class American family. What are the

odds that you or a loved one will face these kinds of health expenses? For most of us, the chance is relatively minor, but the potential loss is so staggering that we feel the need to protect ourselves from it. Hence, we have health insurance as individuals and programs like Medicare as a society.

The problem is, as the system has evolved, health insurance has come to be viewed as something very different from other forms of insurance. Rightly or wrongly, it has come to represent something akin to a prepaid account in which a “use it or lose it” mentality prevails. Compare health insurance to, say, car insurance. In both cases, you generally make monthly payments that are relatively fixed regardless of whether or not you “use” the service. After a car accident, you generally have to pay some kind of deductible above which point the insurance company pays to repair the rest of the damage. If you have some “left over” insurance money, you don't, for example, scrape your car door against a wall to add a few extra repair items to the insurance bill. If you did, you could be sued or even arrested for insurance fraud. This is how auto insurance works.

Now consider the case of health insurance. Depending on the plan, you may have a deductible or a required copayment amount. Regardless of what

ailment prompted you to visit the doctor, you figure that while you're there, you may as well get some blood work done. And while we're at it, let's check your blood pressure too. Have you had a such-and-such done recently? You haven't? Ok, we'll do one of those, too. You think, “Don't worry; after all, it's covered by my insurance plan.” In short, the amount of medical care you consume is often a product of however much your insurance company is willing to pay.

A cursory look at a bill from a routine trip to the doctor's office probably will reveal a list of tests or procedures that you can't pronounce and that you have no recollection of undergoing. However, your personal cost is generally limited to the same \$20 co-pay in any event, so you probably don't think twice about it. You toss the bill into the trashcan and go about your business.

If the above scenario sounds familiar to you, then you are already intimately aware of an issue in economics we call “moral hazard.” (See popout, page I-1) Moral hazard comes into play whenever a third-party pays for a transaction between two primary parties. As in the case of an executive with an expense account paid for by the company, a politician with a comprehensive program that is paid for by taxpayers (such as Medicare), or a college kid with a credit card paid for by Dad, health insurance is fraught with

conflicts of interest. The people receiving and administering the service have no incentive to exercise self control, because, at the end of the day, someone else pays the bill. And by the way, hasn't the patient been paying into the "pool"? Isn't he or she entitled to use it?

This is not to say that doctors are a part of some kind of price-fixing cartel, secretly plotting in smoky back rooms to fleece their patients and their insurers. The truth is to the contrary, in fact. An honest doctor, faithfully exercising his Hippocratic oath, has a responsibility to give his patient the best care possible. The doctor is concerned with the patient's *health*, not the patient's (or insurance company's) pocketbook. To use common business jargon, a doctor is not in a position to do a cost/benefit analysis. If the doctor were to try, it's quite likely that he or she would be sued for malpractice. According to Clark Havighurst of Duke University,

Under the test of "medical necessity"...the criteria used to check the spending discretion of providers are almost exclusively medical, not economic. **Omission of cost considerations from the coverage calculus obviously neglects a principal concern of consumers.** [Emphasis, HS Dent] More ominously, the medical-necessity test perpetuates the values and preferences of health care providers, whose imperative is to prescribe for patients everything that may be beneficial—and nothing but the best.¹

In the cost-benefit analysis of the business world, all expenses are considered at the margin. For example, when hiring an hourly laborer, is that extra dollar in wages justified by at least a dollar's worth of production? In the medical world, this becomes an "any benefit at any cost" analysis. That expensive new prescription drug might have, say, a 10% chance of helping your arthritis, but if someone else is paying, why not go for it?

In other words, when you have a new hammer, everything starts to look like a nail. When doctors have shiny, new, state-of-the-art medical procedures at their disposal, the same logic applies, and cost is all but irrelevant.

But does this really make sense? A professional football player would want the best, most cutting-edge procedure available to repair a blown-out knee, and he or his club would gladly pay for it. But would the same procedure be "worth it" to a banker for Goldman Sachs who spends his workdays in a downtown high rise? If given the option of paying or walking with a limp, the banker might find it worthwhile to save the money and buy a cane.

Herein lies the problem with American healthcare: generally we are unable to make those choices. The decision maker is usually the doctor, the payer is usually an insurance company or the government, and the

patient consuming the healthcare has little to say in the matter. Moral hazard abounds, and we all suffer by way of higher prices for insurance and healthcare.

To return to the analogy of comparing healthcare with car maintenance, a trained mechanic usually can diagnose exactly what is wrong with a car and what it will cost to fix it. There is very little gray area. If the repair does not work as planned, we go back and demand that the mechanic fix it. With our health, we do not have such luxuries. There is plenty of gray area in the diagnosis as well as the treatment, and if the treatment does not work, the outcome can be disastrous.

So, in addition to moral hazards, conflicts of interest, and an understandable lack of cost consideration on the part of care providers, there is the overwhelming sense of "do it right, and do it right now" on the part of the patient, who typically is not the one stuck with the largest part of the bill.

So why does any of this matter? Because our system, which is already under a tremendous amount of stress, is about to get stretched beyond its limits. The largest generation in history—the Baby Boomers—is beginning to turn grey. Add the aging Boomers' increased medical needs to a system that is

already having a hard time keeping costs under control, and we have the recipe for a full-blown crisis. The system as it stands is unsustainable. We cannot consume healthcare at the levels projected; doing so would bankrupt the country or at the very least would elevate health spending to an unacceptable percentage of our finances. So change is coming. The only question is: What form will that change take?

There is no easy answer. Every proposed solution involves a combination of higher costs paid by patients and/or taxpayers in addition to reduced benefits. Addressing these problems often means business or political suicide for the would-be reformer. This is a pending crisis that we all would like to pretend does not exist. Every day that we wait to solve it, the cost of doing so grows larger.

The Demographics of Healthcare

It comes as an unpleasant surprise to many Americans that getting old is expensive. A report in *The New York Times* estimated that a year of life is “worth” about \$100,000 to \$300,000, based on the cost of dialysis and other ongoing procedures for which people are willing to pay, among other factors.² It’s

understandable that most of us never receive an inheritance from our parents, because instead of bequeathing savings, the elderly are using their savings to pay for medical care. The average inheritance—and this includes mega-fortunes that should skew the average higher—is only \$49,000, barely enough to buy a nice car these days.³ Furthermore, only 14.9% of Baby Boomers nearing retirement can expect any inheritance at all. Most parents would love to leave their children a nest egg. Unfortunately, it appears that Mom and Dad often need every last penny to cover their medical bills.

Chart 1 illustrates what we already knew from experience. We spend progressively more on healthcare in general as we age.

Expenses on dentistry level off when we hit our late 40s, much like our consumer expenses in general. (Please visit our site at

http://www.hsdent.com/spendingway_e.php for a more detailed description of consumer spending trends and the implications for the economy.) This makes sense, as costly dental expenses like braces for the kids or cosmetic dentistry for mom and dad as they reach the mid-life-crisis stage generally have been paid for by this point. Spending on prescription drugs and Medicare, however, never really levels off. Quite morbidly, we spend less only after we die.

In the opening lines of this report, we mentioned the Baby Boomers and the impact that they are going to have on our healthcare system. For an idea of things to come, consider that this generation has been a proverbial “bull in a china shop” over the course of its life, radically disrupting the world economy first with their sheer size and later with their new ideas and innovations. This generation—perhaps more than any other in

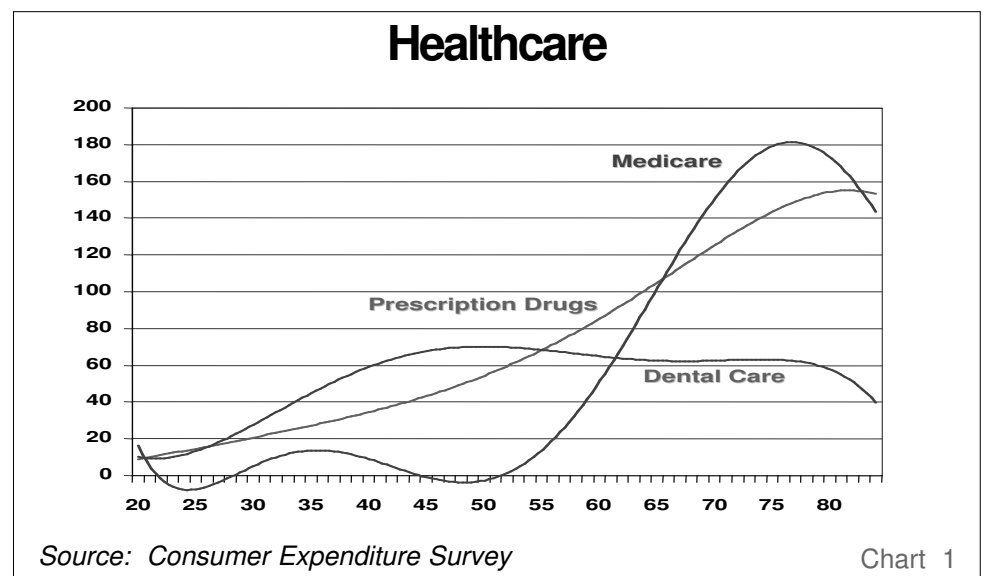


Chart 1

history—truly has defined our age. Their births in the years after World War II heralded the massive expansion of the American suburbs, as their parents needed bigger homes in which to raise them. The surge in the number of school-aged children necessitated school construction on a massive, unprecedented scale. As they became teenagers and young adults, the rock-and-roll culture they created led to cultural and social revolution. (Ironically, as parents today, the Boomers would love to curtail the libertine youth culture that they themselves created in their formative years.)

In the 1970s, the largest generation in history began to enter the workforce en masse. Not shockingly, the entry of millions of young, untrained workers led to the biggest eruption of peacetime inflation in American history. As Boomer workers gained experience in the 1980s, productivity surged, inflation fell, and the economy reached new highs. The 1980s “Decade of Greed” was a result of the Boomers “getting haircuts and real jobs,” rolling up their sleeves, and getting to work. Similarly, the technology revolution of the 1990s was largely the result of the innovations of Boomers like Steve Jobs and Bill Gates who went mainstream.

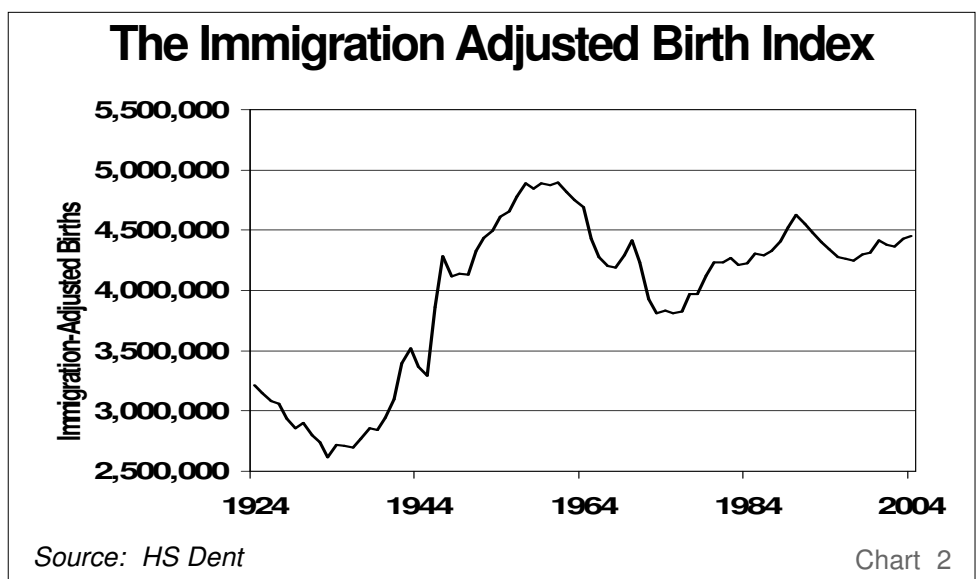
The Baby Boomers’ affect on our economy and society has been compared to “a pig passing through a python,” and for good reason. Now, it is time for this most disruptive of generations to make their presence felt in the healthcare industry.

The Healthcare Wave and the Onslaught of Demand

Chart 2 is one of the fundamental tools of HS Dent research, the Immigration-Adjusted Birth Index. This chart tracks the number of babies born in the US, with adjustments for immigration. The large bulge starting in the late 1930s and peaking in the early 1960s is, of course, the Baby Boomer generation. This tool is extremely useful in predicting significant long-term trends. For example, if you wanted to forecast the

demand for new schools and teachers, you could push the chart forward by five years, given that children born in 2008 would be starting kindergarten in 2013. Using this methodology, we can take our insights from Chart 1 (Health Spending by Age), and combine them with the Birth Index to create a forecasting model for healthcare demand.

The result is **Chart 3**, the Pharma/Healthcare Wave. In this case, we push Chart 2 forward by 76 years, taking into account the average American life expectancy at birth of 78 years. This Wave makes one point abundantly clear: after 2010, demand for health care services—particularly the critical and costly ones that are needed to prolong our lives in our final years—is set to explode. ***Demand for doctors and nurses will rise to levels***

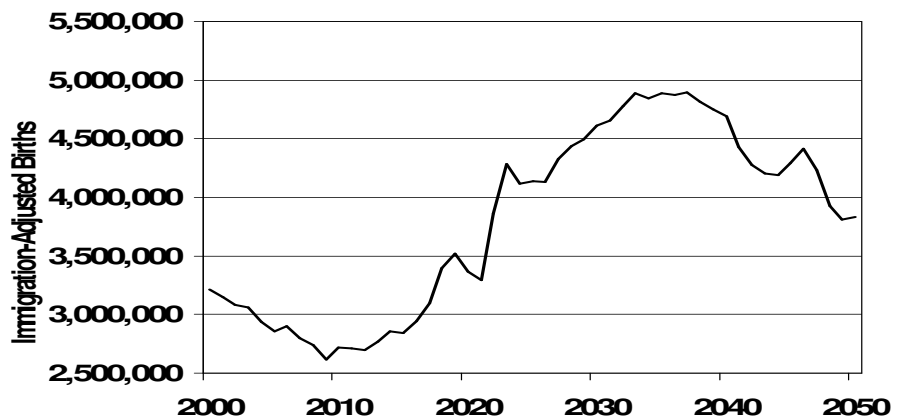


never before seen in peacetime. Demand for critical services and procedures such as heart bypass surgeries and dialysis as well as for non-critical procedures such as hip and knee replacements, will severely strain our medical system.

Already, health personnel needs in the U.S., the U.K., and the rest of the First World are outstripping these countries' supply of native talent. As a result, these countries are "poaching" the developing world of its doctors and nurses. To give an extreme example, 60% of all newly trained health professionals in Botswana emigrate each year, with the largest numbers relocating to the U.K. or to the prosperous parts of South Africa.⁴ Given the steep curve of Chart 3, this is only the beginning.

Rising demand coupled with a limited supply is a recipe for rising prices, which is obviously bad for our budgets. Already, Fidelity Investments estimates that a couple retiring this year would need savings of \$225,000 to cover their healthcare costs in retirement. This is clearly a crisis. However, it is also a potential catalyst for new, cost-cutting innovations and for system-wide reforms. The ability of our health system—and the political system that regulates it—to

The Pharma/Healthcare Wave Births on a 76-Year Lag



Source: HS Dent and The NCHS and INS

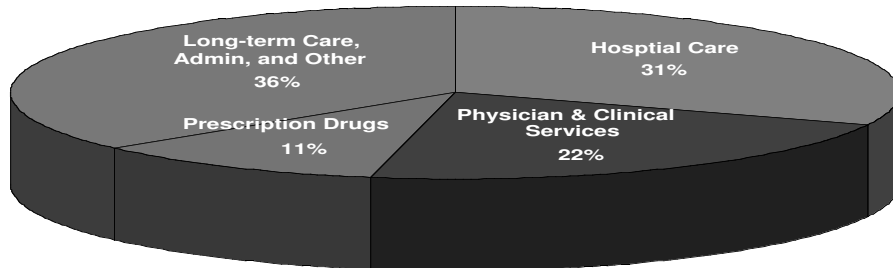
Chart 3

Where Are all of the Health Dollars Going?

Nearly everyone has experienced a shockingly high medical bill at some point. Whether it is a major expense such as childbirth or a major surgery such as hip or knee replacement (or even routine lab work and prescription antibiotics, for that matter), it is easy to come away with "sticker shock" after reading your bill. Americans spend a staggering amount of money on healthcare. So where does the money actually go?

Chart 4 offers a little insight. "Rich" doctors account for only about 22% of total health spending, and this figure includes other clinical services and staff expenses. Prescription drugs account for a paltry 11%, although this number is likely to rise with the aging of the Boomers. Not surprisingly, expensive hospital care consumes a full 31%. However, long-term care dominates the chart—it is the single most expensive "slice." Again, with the graying of the Boomers fast approaching, this number is likely to skyrocket. Not only will the sizes of the slices shift in the coming years, but the entire pie also will be much, much bigger.

Total Health Spending



Source: "Improving Health Care: A Dose of Competition." July 2004 Chart 4

find new, cheaper ways to deliver the services needed likely will be the defining issue of the coming decades.

Mediscare

Nothing in American politics seems to elicit more extreme opinions than Medicare. Like Social Security, this program has developed a reputation as a "third rail," with the implication that any politician stupid enough to touch it will be electrocuted to death. As President George W. Bush discovered, it's relatively easy to add new benefits (such as his prescription drug plan), no matter how expensive or economically dubious. Any attempt to scale back benefits, however, is political death. This is unfortunate, because the system in its current form is unsustainable. Indeed, starting in 2005, Medicare began running a fiscal deficit, in which the program spends more than

it brings in through its dedicated tax income each year. Where does the difference come from?

The Medicare program spends some of its built up "trust fund," which is nothing more than a series of U.S. government bonds. Whenever Medicare runs a deficit and must cash in some of its bonds to pay for the difference, the U.S. government has to come up with the cash from somewhere else—issuing more bonds to other people—which in effect increases the overall U.S. debt.

In his recent book *Medicare Meets Mephistopheles*, David Hyman suggests, tongue in cheek, that the entire Medicare program was a plot from Satan himself to bankrupt the United States of America. The implication is that, like Faust, we have "sold our souls" to live for the moment. Even if this is a little harsh, it can't be denied that there will be a "day of reckoning"

of sorts, although it won't be the Devil who comes to collect. It will be us as medical consumers, when we demand the generous Medicare benefits that we promised ourselves and have been paying all of our working lives for older generations.

Medicare is often derisively called a Ponzi scheme as well, and not without some justification. After all, current beneficiaries are not paid with "income" from investments they made themselves over time, but instead have their benefits paid for with the cash contributions of future beneficiaries. Due to the demographic changes that we described above, this becomes very expensive to maintain. How expensive? Government estimates give us an unfunded liability of over \$30 trillion—**more than 10 times the current annual budget of the U.S. government!**

Medicare's biggest problem is the demographic composition of the country. Right now the ratio of the number of workers paying into Medicare for each retiree who is covered is 3 to 1. As Boomers retire, this ratio gets worse (meaning less people pay in per retiree), approaching 2 to 1.

So as we move into the next phase of life for the Boomer generation, we have a system that is marching higher in cost, with little incentive for the patient or recipient to slow down

expenditures and fewer people paying for it. Any one of these issues by itself would be problematic at the least, but to have all of them together creates something of a perfect storm. There is no clear-cut answer as to what *will* happen. The only thing that is certain is that something, in terms of changing the system, *must* happen. That “something” will come in the form of (1) lower benefits for recipients of healthcare; (2) higher payments by those paying for the care, which for the Medicare system is the taxpayer; or (3) a combination of the two. Before we look at our economic situation for the years to come, we should examine the structure of the Medicare system to understand better how we got here.

Paved With Good Intentions

Beyond the bad demographics, Medicare has a host of structural problems. Most of these stem from the program’s attempts to keep cost down, which ironically tend to have the opposite effect. Due to Medicare’s sheer size, it has the effect of massively distorting the pricing structure of the entire medical industry. Doctors, naturally wanting to get paid for their work, have every incentive to game the system and bill Medicare for the maximum amount possible, regardless of medical need or economic

sensibility. Dr. Peter Bach, former senior adviser to the Centers for Medicare and Medicaid Services, offers these insights:

The typical Medicare patient in one year sees seven different doctors, including five different specialists, working in four different practices.. ..Forty percent of the patients in our study had seven or more chronic conditions and they saw on average 11 doctors in seven practices; the upper quartile of this group saw 16 or more different doctors in nine or more different practices.

Healthcare is like this because of the way that doctors are paid. Few doctors receive an hourly rate or a set annual salary; most are paid according to a system called ‘fee for service,’ in which visits, test and procedures are reimbursed separately. **Doctors face incentives to provide more services and more expensive services, and so they do just that.**⁵

The very existence of Medicare causes demand for health care to

rise, but not only due to the inefficiencies described above by Dr. Bach. There is also the consideration that millions of Americans who might have avoided a trip to the doctor due to the costs involved suddenly can “afford” it. It’s the moral hazard issue rearing its ugly head again. Americans who might never have had insurance in their entire working lives suddenly had it for free when Medicare was introduced by Lyndon Johnson. The introduction of the program and the increase in the number of people insured as a result caused a **nearly-immediate 37% jump in total hospital spending.** Using this estimate, the *Wall Street Journal* estimates that **Medicare alone accounts for about half of the six-fold increase in real, per-capita healthcare spending between 1950 and 1990.**⁶ (It could be argued, of course, that this is not necessary a bad thing. The elderly Americans enjoying the benefits certainly would not have thought so!)

And then, of course, there is self-dealing and sometimes even outright fraud. The General Accounting Office says that \$1 out of every \$10 paid out by Medicare is wasted, thanks to double and triple billing by providers or overcharging by equipment suppliers.⁷ Even more, the costs of superfluous, unnecessary care, such as that described by Dr. Bach above, is incalculable. *The New York*

Moral Hazard at the Doctor's Office

No, this section has nothing to do with stem cell research or doctor-assisted suicide. Moral hazard is a very real phenomenon whenever people are shielded from the consequences of their decisions. It is a particular problem in the case of insurance. Consider the recent and high-profile case of the Hurricane Katrina disaster in New Orleans. Is it wise for builders or city planners to allow homes to be built below sea level and next to a levee? Of course not. But as long as the insurance company or the government pays the bill in the event of disaster, who cares? Despite every warning not to, much of the flood-prone areas of New Orleans are busily being rebuilt.

Banking is another fine example. Before the Great Depression, there were no protections on your savings other than the good reputation of the bank holding them. A prudent saver in that era would only deposit his or her hard-earned cash in a conservative, safe institution. Unfortunately, the Depression nearly took down the entire banking system, good and bad banks alike. As a result we now have FDIC federal insurance that protects your savings in the event that your bank fails. Most economists view the development of FDIC insurance as a good thing, in that it encourages savers to take their cash out from under the mattress and put it into the system, where it can be used to finance economic growth. Of course, the very same economists would add the caveat that this insurance also has the effect of encouraging excessive risk taking and general carelessness by depositors. After all, why bother investigating the bank's solvency if the government is the one shouldering the risk?

"But," you might protest, "there are costs to the consumer. Homeowners pay more for insurance premiums after major claims are filed and we all pay more in taxes after a federal 'bail out' of a failed bank."

Yes, this is true. ***But the incremental cost to each individual is small relative to the cost to the system as a whole.*** Sure, you may pay a couple hundred extra dollars per year in flood insurance premiums. But the insurance company had to shell out many *thousands* of dollars to repair or rebuild your house. This is moral hazard in action.

And believe it or not, the situation is even worse when it comes to healthcare for a number of reasons. First, healthcare, rightly or wrongly, has a sense of entitlement that other expenses simply do not have. People believe that they have a right to healthcare, or at the very least, a right to "not die." Not shockingly, this idea that cost is irrelevant when it comes to saving or improving lives leads to higher costs. Adding to this is the fact that Medicare is the ultimate payer in many cases, and most people (again, rightly or wrongly) seem to have no moral qualms with soaking the government. Most patients probably don't even realize that they're doing it.

For perhaps the best analogy to the moral hazard issue, consider Richard Epstein's analogy of teenagers sharing a soda:

Think of two ways in which a group of 10 teenagers can drink soda at a luncheon counter. One is to get a large pitcher and have 10 thirsty kids each use a straw to take out what he or she wants. The second is to divide the soda into glasses, and assign them one to a person. Let there be 10 pints and each teenager's initial entitlement is one pint either way. The patterns of consumption of the soda will not be the same in these two arrangements. Even if by some miracle each person gets the same amount of soda in the two configurations (which they won't), we can be 100 percent confident that the soda will be more rapidly consumed when all 10 teenagers slurp their soft drink from the common pitcher. Consumption rates will slow markedly if each has his or her own glass, for slow sipping now results in greater satisfaction, not a reduction in individual share.

Richard A. Epstein

Foreword to *Medicare Meets Mephistopheles*¹

During the 1990s, there was an enormous public backlash against "Hillarycare," as Americans were not ready at the time for socialized medicine. The truth, however, is that we largely *already have* socialized medicine in the form of Medicare, and not just for those over the age of 65. In a recent editorial, *The Wall Street Journal* went so far as to call it "Soviet" medicine. While it may be bit of an exaggeration to compare Medicare to the old USSR, there are some similarities

that the *Journal* notes: “The essential problem is this. The pricing of medical care in this country is either directly or indirectly dictated by Medicare; and Medicare uses an administrative formula which calculates ‘appropriate’ prices based upon imperfect estimates and fudge factors. Rather than independently calculate prices, private insurers in this country almost universally use Medicare prices as a framework to negotiate payments.”² Market prices set by a government planning authority? Come to think of it, that *does* sound rather Soviet.

This adds an entirely new element to the moral hazard that plagues the industry. Not only do patients push all responsibility for controlling costs into the hands of insurance companies, but the companies themselves push all of the responsibility into the hands of Medicare! If an insurance company is overcharged for a routine procedure, they can simply raise premiums on the patient’s insurance plan and then blame the Medicare pricing scheme for the whole debacle. In the case of company-sponsored plans, an additional level of unaccountability is added since the premiums are paid by the company, not the user of the insurance. Since none of the players involved has any incentive to exercise discipline, it’s no shock “*excessive and unjustified costs consume as much as 20% of health care spending.*”³ With no real responsibility at any point in the chain, it’s shocking that our system isn’t even more dysfunctional that it is.

The Mechanics of Moral Hazard

To review, moral hazard is the problem arises when one person gets the benefits and someone else pays the bill. One of the best explanations of the phenomenon to date was Mark Pauly’s 1968 paper published in the *American Economic Review*.⁴ One of the points that Mr. Pauly emphasizes (and that we reiterate in this report) is that health insurance offers incentives for patients to over-consume healthcare. True insurance is designed to protect the policyholder from random, unpredictable, and catastrophic events, such as your house being struck by lightning; insurance is not designed to pay for routine house painting and maintenance. Yet somehow, these same principals have been lost in health insurance. We don’t buy health insurance just to protect ourselves from catastrophic diseases, like cancer. We also use it for

yearly flu shots and amoxicillin, the medical equivalents of painting and routine maintenance. In practice, it appears that we do not view health insurance as insurance at all, but rather as a medical pre-paid card. More accurately, it could be described as a gift certificate in that we end up buying things that we would never normally buy if we were using our *own* money. The result is that we over-consume on expenditures that are often frivolous and drive the price higher than it needs to be.

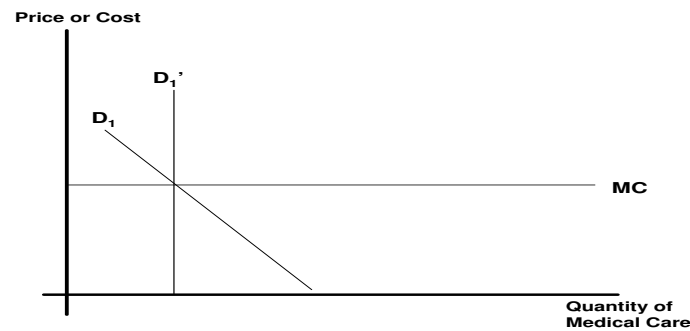
Pauly writes:

*[In order for health insurance to be optimal], the costs of medical care must be random variables. But if such expenses are not completely random, the proposition no longer holds. **The quantity of medical care an individual will demand depends on his income and tastes, how ill he is, and the price charged for it.** (Emphasis HS Dent) The effect of an insurance which indemnifies against all medical care expenses is to reduce the price charged to the individual at the point of service from the market price to zero.*

Whether or not insurance encourages over-consumption depends on the elasticity of demand for healthcare. To translate “economist speak,” the elasticity of demand refers to how flexible your purchase decision is. Your demand for food is inflexible; you need it to live. But your demand for, say, beef is very flexible. If it gets too expensive, you can buy chicken instead.

Chart M1 illustrates this graphically. Line D_1 ’ is an example of inelastic demand, and as you can see, the amount of healthcare demanded is the same at all price levels. This is pretty close to reality for life-saving procedures, such as an emergency heart bypass surgery. Most medical decisions look a lot more like D_1 , however. On line D_1 , the amount of care demanded decreases as the price increases. There are quite a few noncritical medical procedures you might be willing to forgo were the price high enough. They might be highly desirable, but at some price they are just not worth it. This is where over-consumption and moral hazard comes into play.

Demand for Healthcare



Source: Adapted from Pauly 1968

Chart M1

As Pauly continues:

Each individual may well recognize that 'excess' use of medical care makes the premium he must pay rise. No individual will be motivated to restrain his own use, however, since the incremental benefit to him for excess use is great, while the additional cost of his use is largely spread over other insurance holders, and so he bears only a tiny fraction of the cost of his use.

This is Epstein's pitcher of soda analogy in action. The teenagers end up drinking more soda and drinking it faster with little if any effect on their portion of the lunch tab. So what's the solution? Abolish all forms of insurance? Doing so would eliminate moral hazard and almost definitely lower prices, but is that really what we want? Most people would lack the financial means for pay for major surgeries and life-saving treatments when they became necessary. Clearly, some kind of insurance is needed. Pauly suggests restricting insurance to cover only catastrophic and relatively random illnesses. This would be consistent with new products such as Health Savings Accounts ("HSAs"), which combine a high-deductible insurance policy with a tax-advantaged savings account. Since it is the *patient's* money and not the insurance company's at stake, patients and doctors alike are likely to use a little more discipline. The result should be lower medical bills, lower premiums, and less over-worked doctors.

While any form of insurance is bound to introduce moral hazard into the system, this is not entirely bad. As Clark Havighurst explains, "A degree of moral hazard is a natural concomitant of any arrangement, private or public, that gives people security about their future health care costs. Because such financial security is valuable to people, it is not irrational to incur some higher costs to obtain it."⁵ Well said, and we agree completely. The key will be to keep the costs moral hazard in the health industry to a tolerable minimum, especially given the demands that our system will face as the Boomers age and require ever-increasing amounts of care. For any system to be viable with a looming burden as large as the one we face, there must be a mechanism to make consumers more financially accountable for the services they use.

¹ Hyman, David A. *Medicare Meets Mephistopheles*. New York: The Cato Institute, 2006.

² Swerlick, Robert A. "Our Soviet Health System." *Wall Street Journal*, June 5, 2007

³ "Slicko." *Forbes*, August 13, 2007

⁴ Pauly, Mark V. "The Economics of Moral Hazard." *The American Economic Review*, Vol. 58, No. 3, Part 1 (Jun., 1968), pp. 531-537

⁵ Havighurst, Clark C. *Health Care Choices*. Washington, DC: The AEI Press, 1995.

The “Nuclear Option”

For a fine example of the “any benefit at any cost” analysis at work, consider this statement from the *New York Times*:

There is a new nuclear arms race under way—in hospitals.

Medical centers are rushing to turn nuclear particle accelerators, formerly used only for exotic physics research, into the latest weapon against cancer.

Some experts say the push reflects the best and the worst of the nation’s market-based health care system, which tends to pursue the latest, most expensive treatments—without much evidence of improved health—even as soaring costs add to the nation’s economic burden.ⁱ

The *Times* reports that, at \$100 million each, these proton centers are the most expensive and complex medical device ever made. Naturally, any doctor or hospital making such an investment will want to use it at any and every opportunity, even in cases for which a less costly alternative would work as well, such as localized prostate cancer in men.

There is virtually no disagreement among experts that the new proton therapy is superior to the traditional x-ray radiation treatment currently used to treat tumors. The debate simply becomes: “How *much* better is the treatment, and is that marginal improvement worth the significant increase in cost?”

When we are talking about our own bodies (and someone else is paying), money is no object. But were we paying cash...well, we might have to give it some thought. It’s that moral hazard problem that just never seems to go away.

But beyond the moral hazard issue, which by now must be sounding quite tired, there are others factors that many onlookers might consider overuse of the system.

A separate article in the *New York Times* covers the growing numbers of “previvors,” or women who have “pre-survived” breast cancer before any symptoms were detected by undergoing a pre-emptive double mastectomy—just in case they were to develop cancer later.ⁱⁱ We certainly do not fault any person for being terrified of cancer, particularly if she has a strong genetic predisposition to develop the disease. Fear can motivate people to take drastic measures. But undergoing the amputation of healthy tissue and the extensive reconstructive surgery that follows would seem quite extreme.

Again, this is not to minimize the fear and angst that would lead a woman to take that course. However, the end result is that scarce medical resources—in this case treatment for breast cancer—are being diverted to patients who are not showing any symptoms. We have increased demand with constrained supply, and this is a recipe for higher prices. This means that women currently fighting cancer have to pay more for their treatments and have to compete for limited time with their doctors and that virtually all women pay more in insurance premiums and higher taxes.

As healthcare costs continue to rise, there will be friction between those who believe that a procedure is a necessity, such as doctors and worried patients, and the insurance companies and government agencies that are forced by economic constraints to say “No.”

ⁱ Pollack, Andrew. “Hospitals Chase a Nuclear Tool to Fight Cancer.” *New York Times*, December 26, 2007.

ⁱⁱ Harmon, Amy. “Cancer Free, But Weighing a Mastectomy.” *New York Times*, September 16, 2007.

Times gives a fine example of how Medicare's incentive structure encourages profligate waste, borderline criminal behavior, and untold amounts of unnecessary pain for cancer sufferers:

When Medicare cracked down two years ago on profits that doctors made on drugs they administered to patients in their offices, it ended a windfall worth hundreds of thousands of dollars a year for each physician.

The change, which mainly affected drugs to treat cancer and its side effects, had an immediate effect. In all, cancer doctors billed about \$4.4 billion for chemotherapy and anemia medications in 2005, down from \$5.6 billion in 2004, with Medicare covering 80 percent of the bills in each year. The difference mostly represented profit that doctors had made on the drugs.

But the change did not reduce overall federal spending on cancer care, which increased slightly. And cancer doctors say the change did nothing to reduce a larger problem in cancer treatment. Some physicians say that cancer doctors responded to Medicare's change by performing additional treatments that got them the best reimbursements, whether or not the treat-

ments benefited patients. Those doctors also say that Medicare's reimbursement policies are responsible.⁸

Our goal here is not to bash doctors. If doctors are not allowed to be paid what their services are worth on the market due to Medicare pricing minutiae, can you really blame them for attempting to make up the lost dollars elsewhere, so long as the patient doesn't suffer? Of course, this also could be viewed as insurance fraud. This is a topic we'll explore further in the section on corporate group health insurance policies. Suffice it to say, Medicare's payment structure is a major contributing factor to the bubble in medical costs.

Is my Employer Ripping me off? The Problems With Company Insurance Plans

As big as Medicare and Medicaid are, most Americans still get their health insurance through their employer or the employer of their spouse. For these Americans, health insurance is something that has rarely crossed their minds. It was an added perk provided by the company that came in handy whenever the kids got the flu, but since the

employees never had to pay the premiums themselves they had no reason to give much thought to the matter—until now. Due to soaring health costs, companies are being forced to cut or to reduce their employee insurance plans or at a minimum to require their employees to pay higher deductibles or co-payments. This unexpected hit has led plenty of Americans to feel as though they have somehow been victimized or that they've had a fundamental right stripped away from them. This is an emotional issue, and rightfully so. A person's health and pocketbook are two things that he or she take seriously.

With the coming stresses we see hitting our healthcare system, we believe that the trend toward less-generous employer coverage will continue. We also believe that major changes to the entire employer-funded insurance regime could be in the works. This would involve major new legislation by Congress, which is always a wild card. The current regime, though flawed, has been in place for decades, and it's never easy to institute major reforms when there are vested interests in place and voters to keep happy. With this in mind, let's take a look at the issues involving employer-funded insurance and explore possible reforms on the horizon—and what effects those reforms will have on your coverage.

The...view, held by almost all economists and policy analysts...is that employer payments for health insurance premiums ultimately come out of what would otherwise have been money wages for workers. In this view, higher medical costs do not harm employers or owners but do reduce money wages for workers—and harm them if the additional costs are not associated with sufficiently high additional health or security benefit. Lower costs benefits workers, not employers; they add to take-home pay, not profits.

As the quote above (Mark Pauly, “Health Benefits at Work,” 1997) explains, health benefits are another form of compensation, in theory no different from your regular paycheck. In fact, this is exactly why many companies began to offer health insurance during World War II. Strict wage and price controls limited the cash wages that companies were allowed to pay, but the labor shortage throughout the war made it hard to attract and retain workers. Companies discovered that they could circumvent the wage restrictions by paying their

workers with benefits. It’s been an integral part of our labor market ever since.

In theory, the money that is paid by your employer to supply you with health insurance is money that would have otherwise gone to you in the form of cash, so in economic terms benefits and wages are interchangeable. Yet workers and employers alike do not appreciate this as such. Employers complain about the high costs, and employees do not fully understand the value of the “pay” they receive in the form of the insurance. They tend instead to focus purely on regular W2 wages. Likewise, employers also tend to view this benefit as a separate cost rather than as a part of regular wages, because health insurance has an almost mystical value. Cutting health insurance is viewed as somehow being more heartless than simply reducing wages or even laying off workers. So, while workers and employers *should* be indifferent to substituting higher wages in lieu of health insurance, generally they are not. Irrational value is given to health insurance.

This trend is aided by the tax system. As Pauly elaborates,

...that portion of compensation paid as health insurance premiums receives special tax treatment. Such payments are permitted as a deduction (‘cost)

from gross revenues for purposes of calculating an employer’s taxable net income; they are also excluded from the base of the employer’s share of the payroll tax for Medicare and Social Security. **For employees, such payments do not increase either income or payroll taxes; they are excluded from taxable income and wages.... No tax is paid on the value of the medical benefits received.**⁹ (Emphasis, HS Dent)

The federal tax subsidy for employer-funded insurance is no small amount. In fact, it is estimated to be well over \$188 billion, or about 29% of all private insurance spending.¹⁰ Of course, the federal government never really *pays* for anything; we do, as taxpayers. So in effect, we are subsidizing our own healthcare, right? It shouldn’t matter how we pay the bills so long as they’re getting paid, right? Wrong.

The problem with any subsidy is that it always introduces moral hazard to the system and creates new inefficiencies. Companies have an incentive to provide a

higher and higher percentage of total wages as health insurance due to the tax subsidy. This creates artificially high demand and causes the price to rise for everyone, especially for those individuals without employer coverage who are forced to buy retail policies.

The rising cost of healthcare has generated calls for the government to “do something,” and it seems that many politicians are trying to offer plans to “fix” the insurance market. As Clark Havighurst explains, this is really a case of barking up the wrong tree:

At present, poorly designed tax subsidies for the purchase of employee health benefits induce people to purchase coverage that is excessively tolerant of moral hazard. But that is a failure of government tax policy, not a market failure obviously calling for government intervention in the industry. Although the equilibrium that the market seeks is undoubtedly affected by tax subsidies, those subsidies are similar to other subsidies in the economy (such as for agriculture or residential housing) and do not in themselves invalidate reliance on the market finally to allocate scarce resources.¹¹

Currently, the tax subsidy is one of the factors distorting the market and causing health insurance premiums to rise. Employees receiving insurance—through no real fault of their own—have no real way to gauge the cost of the health bills they rack up at the doctor’s office and no real incentive to change their behavior even if they did. Although all employees and all taxpayers suffer as a result, no single individual has an incentive to change, because the added costs to that one person are so small as to be insignificant. It’s the moral hazard issue yet again.

Some mechanism is needed to help the people benefiting from health insurance to realize the full value of the service they are consuming. In his 2007 State of the Union address, President Bush proposed changing the tax accounting for health benefits. In the Bush proposal, all employer-paid insurance would, for the first time, be counted as taxable income for employees. At the same time, there would be an immediate tax writeoff for individuals for all health insurance, whether paid by employer or out of pocket. For people currently receiving benefits, this would be a tax-neutral event.

Several Democrats in Congress have raised some valid objections. Would this change cause employers to stop providing insurance? If they did, would wages rise high enough to allow the employees to buy

insurance on their own? Even if they could buy it on their own, would they? Or might they choose to go uninsured? Would all of this simply drive us closer to universal, government-provided health insurance? These are questions that have no answer, given that the only way to know for sure is to institute the change and judge the reaction. Of course, by that time it might be too late if many people are left without coverage. The issue has severe consequences, so any misstep could be disastrous.

The fact remains, the flaws in the system have contributed to the rise in the cost of healthcare and insurance. This inflation in prices has, in turn, caused some employers to begin to reduce the health coverage they provide or eliminate it altogether. Regardless of the direction of the U.S. tax code, we appear to be in the early stages of a new trend. More and more companies are beginning to require that their employees contribute more to the healthcare bill. Some are taking the even more radical step of doing away with “group plans” as we know them and switching instead to more individualized products like Health Savings Accounts (HSAs).

One of the problems with pooled group health insurance, is that it is a “one size fits all” approach to insurance. Heavy users and light users, risk averse and risk tolerant, all use the same policy. Were they to buy their own

policies on the market, however, different people probably would purchase very different policies. A single 25-year-old male might be content to have a high deductible policy, because he is unlikely to use it except in the event of a medical emergency. A father or mother who regularly takes children to the doctor obviously would prefer something with a lower deductible.

HSAs, although not a panacea, provide some flexibility along these lines. Employers can offer high-deductible policies to their workers, also giving them cash that can be used for current health expenses. Workers who choose not to use the cash—such as, perhaps, the 25-year-old male described above—could let the cash grow, tax deferred, in the HSA account, much like an IRA or 401k for *future* health expenses with a *future* wife and kids.

In any event, decision making is increasingly being forced down the chain to the consumer. We view this as a step in the right direction. Steps taken now to combat moral hazard should help to lower health costs considerably. With the onslaught of new demand for healthcare coming (remember Chart 3), every little bit helps.

The Poor, The Sick, and The Uninsured

Perhaps the single biggest political issue being discussed today is the problem of “the uninsured.” A significant number of people are uninsured in this country, and many of them are children. This fact is oft repeated by countless politicians as a mark of national shame and a call to action. Everything from mandatory insurance policies to fully socialized medicine has been proposed. Mitt Romney’s “RomneyCare” program in Massachusetts has been used as a model for the country as a whole. Nearly every suggestion involves some kind of new subsidy for the poor. There are several reasons to believe that this is a potentially costly and burdensome mistake. Writes Kevin Sack in the *New York Times*,

First, for many of the uninsured, it is unlikely that poverty is the reason they do not have health insurance. Many uninsured individuals who are eligible for Medicaid or other forms of public insurance simply fail to enroll. For example, most of the 9.3 million uninsured children in the United States are eligible for government sponsored health insurance. Similarly, half of

California’s poor...are eligible for the state’s health insurance programs but do not enroll.¹²

California is not alone. In Texas, 850,000 children are eligible for Medicaid or Schip but not enrolled, even though the state runs radio ads and passes out brochures in multiple languages, and works with community organizations to make parents aware.¹³

Similarly,

Despite a decade of marketing efforts by governments and private foundations, nearly 30% of children who are eligible for the health insurance program [State Children’s Health Insurance Program (“Schip”)] and are not covered by private plans have yet to enroll....Studies have found that about two-thirds of all uninsured children are eligible for [either Schip or Medicaid].¹⁴

Why? In addition to the obvious reason that even at a low cost there are those who cannot afford it, perhaps some in this group either don’t think that they are going to get sick or choose to

spend the money on other things. It might not be an important priority for them at the moment, or it could be that some small percentage is simply too irresponsible to fill out the forms. Many of the uninsured are young adults and 20-somethings who might prefer to spend their cash on a new cell phone or iPod, so this is not an unreasonable question to ask. It's not clear that additional social benefits would be of much value given that existing ones are not being utilized.

The much-heralded Romney-Care mentioned above has been billed as a silver bullet: "liberally" providing health insurance for all, but "conservatively" making them pay for it. At the time of its creation, then-Governor Romney was viewed as a visionary. As a 2008 presidential candidate, however, Mr. Romney attempted to distance himself from his pet project. As it turns out, legally mandating that citizens buy health insurance is not a panacea, and the program has come under fire for numerous reasons. To start, civil libertarians point out that Americans have always resented heavy-handed mandates from above, and it is open to legal debate whether a state can force a citizen to buy health insurance. Proponents say that this is little different from state laws that require motorists to buy liability insurance for their cars, but that requirement only applies to car owners who drive on public roads. You certainly don't have

to pay if you don't own a car. In contrast, in the case of RomneyCare, if you live in Massachusetts you must purchase private insurance or pay a penalty. There is no way to opt out.

This says nothing of the massive conflicts of interest created by mandating that citizens do business with private companies. Some corruption and outright fraud is almost inevitable in such an arrangement. What would stop insurance companies from using their new influence with the state to raise prices or reduce services covered? Under the law, the citizens of the state are practically captive buyers who now no longer can "vote with their feet" by canceling their contracts. The costs of this program are expected to skyrocket for both consumers and for the Massachusetts state government, which is on the hook to subsidize the care of thousands of residents, and the result is likely to be harsher punitive regulations by the state and even fewer choices for consumers.

There are other, less philosophical, problems as well. The uninsured, single 25-year-old male described above has not run out to buy insurance to be in compliance with the law. Why not? Because the tax penalty for failing to comply is smaller than what he would have to pay for insurance under the law. He's saving money by not complying, and being a typical 25-year-old

single male, health insurance is simply not a high priority. This leaves a large hole in the funding the program, which hangs, on charging those who don't use the program—25-to34-year-old men, typically—in order to pay for those who use more than their premiums cover.

The Cato Institute reports that between one half and two thirds of Massachusetts residents who were uninsured before RomneyCare's implementation remained so at the beginning of 2008 and that those who have signed up are disproportionately older and sicker than the general population.¹⁵ Furthermore, costs have spiraled out of control. The plan's generous 2008 budget of \$1.8 billion is projected to be exceeded by a full \$150 million; over the next ten years, the cost overruns are likely to total \$2 billion.¹⁶ *The Wall Street Journal* estimates that the cost to the state directly—or, more accurately, to the taxpayer—will be over budget by 85%.¹⁷ Even if these numbers are slightly off, we are talking about a lot of money.

Governor Romney deserves credit for making a real effort to combat the health crisis in his state. Certainly, we believe that he and his legislature acted with the best of intentions. Unfortunately, their brainchild appears thus far to fall short as a solution to a very complex problem. No grand plans will "solve" the healthcare crisis. At best, good policy changes can be combined with benefit re-

ductions and better informed and empowered consumers to make the problem more manageable. But, with the Boomers entering their golden years, this problem is not going away any time soon.

The Future of Medicine?

Why is it that technology makes everything—from cars to computers to banking—cheaper, yet healthcare, in spite or perhaps *because* of technological improvements, actually gets more expensive? A new computer off of the shelf generally will have twice the power as the one on your desk, and will probably cost half as much. Yet new medical procedures rarely seem to cause older ones to decline in price.

Why is it that the high-tech health industry appears to be immune from the natural forces that produce price deflation in other tech-driven industries? A one-word answer would be, “people.”

Manufacturing and information technology companies have what economists call “economies of scale.” General Electric can produce aircraft engines at a competitive price because the company has the size and order flow to produce them efficiently. Many tasks can be automated by computers and robotics. Although large amounts of human labor are used, that

human labor can be “scaled” by the use of machines.

The economics of information technology and software are even better. Microsoft makes an enormous initial investment to create a new version of Windows, but once that investment is made, nearly infinite copies of the system can be produced at no real additional cost. To a lesser extent, the same is true in our own publishing business. It is expensive to do the research contained in this report and to produce the graphics, layout, etc. But once those costs are incurred, the knowledge in this report can be reproduced virtually an infinite number of times simply by hitting the “print” button.

Now, let us contrast this to the medical industry. Medicine is and always has been a service industry, like law or accountancy. But unlike law and accountancy, in which modern software programs have the ability to leverage the skills and knowledge of professionals by automating some of the more simple tasks, such as standard business documents or tax returns, there can be no real leveraging of a doctor’s time. Medical professionals are knowledge-based service workers, and their jobs require personal attention. Whether we are talking about a doctor, a nurse, or even a lab technician, we are talking about a person, complete with all of the expenses that a person entails—everything

from a paycheck to coffee for the break room. While TurboTax can do your taxes, there is no TurboNurse that can change your IV bag.

So medicine is simultaneously cutting edge *and* hopelessly archaic. Generally, medical services cannot be scaled by technology and cannot be outsourced to India or China. This is a recipe for rising costs.

Medical jobs are “anchored,” in Thomas Friedman’s terminology. In this sense, they are like those of plumbers or barbers. When you need a broken pipe fixed or need your hair to be cut, you pay for these services close to home. You don’t call in a plumber or barber from India or even from Indianapolis, Indiana, unless you happen to live there. Most medical care is the same. This is good for doctors but fundamentally bad for the consumers and insurers that pay the bills. This is, in part, why we pay \$600 for 8 minutes of a doctor’s time and a pop on the knee with a rubber hammer after waiting in a crowded office for two hours like a refugee.

There is hope, however. The technological revolution that has “flattened” so many other industries finally may be coming to medicine. Given the rising costs that we are already experiencing (and that will only get worse as the Boomers age), this is a necessity for maintaining our standard of living as a

nation. Writes Andy Kessler in *The End of Medicine*,

Get the people out. People are expensive... Technology is liberalizing and democratizing every industry you can think of. The New York Stock Exchange is toast. Your phone company is shrinking. Broadcast TV and newspapers are starving for growth. We can take it in our own hands and use the Web to trade stocks, make phone calls, read news, and even watch videos. But why can't we take charge of our own healthcare?

...if I learned one thing in the last year, it's that change was starting to take place in medicine, and was only going to accelerate. Laparoscopic gallbladder surgery is cheaper and became the norm. Why? Because it reduced hospital stays. Hospitals are where people work and people are expensive. Doctors, nurses, orderlies, bedpan emptiers, pathologists, administrators—they've all priced themselves out of existence.

It requires an insane amount of study to become a doctor, and with good reason. You don't want an illiterate high-school dropout cutting you open with a scalpel. But today, much of a doctor's knowledge can be digitized, reduced to a series of yes/no questions that can be embedded in a chip and answered by a blood test. Imagine walking into a pharmacy and dropping a small vial of your blood into a machine that could, after a few minutes of processing, print out a report with a simple checklist of ailments. Should the computer detect any red flags that require real attention—such as high blood pressure, possible cancer, etc.—you could be referred to an actual doctor or specialist. Is this farfetched? Not at all. As costs continue to rise, solutions such as this will become more and more viable.

Google and Microsoft both already are participating in the revolution. Some 52% of American adults sometime or frequently consult the World Wide Web for health information.¹⁸ Sites run by these companies can store your health information and can allow you to search efficiently for information. This could include a health profile for medications,

conditions, and allergies; a personalized health guide for suggested treatments, drug interactions, and diet and exercise regimens; and even reminder messages to fill prescriptions or to visit the doctor. This could be done using your actual health records or could be done anonymously by filling out generic forms about your age, health conditions, etc., and running against a database. As described above, all of the existing medical knowledge in the world could be digitized into a database of "if X, then Y" statements such as, "If enzyme X is present in blood, then heart condition Y might be a potential problem. See a cardiologist immediately."

McDoctor

Another welcome development is the retailing of healthcare. Wal-Mart, CVS, and Walgreens all have created "convenient care" clinics in selected locations. These clinics generally are run by a doctor or nurse practitioner, and no appointments are needed. The clinics are open 7 days per week, often for extended hours, so the days of having to lose an entire day of work to have a doctor examine your child's sore throat potentially are over. Many visits can take as little as 15 minutes, and visits generally cost only \$40 to \$70 each.

This is an excellent business model. Common, routine medical issues such as flu shots and antibiotics for strep throat now can be done at your local Wal-Mart, which frees up the caregivers at doctors' offices and hospitals to spend their time on more serious cases. In business lingo, the doctors' offices can focus on "higher value added activities," and the lower-end work can be "outsourced" to the McClinics. The consumer benefits from lower prices and greater convenience.

With these new technologies and business models, we have the potential massively to improve our medical system and to lower cost, and all of this can be done without expensive and time-consuming new government programs and/or regulations: no new forms to fill out! In fact, current regulations at the state and local levels are what are preventing Wal-Mart and the major pharmacy chains from expanding their clinics more aggressively.

We have no way of knowing what impact new government involvement will have on these developments, but we are encouraged to see, at the very least, that new ideas are out there and being discussed. Every little bit helps, because the challenges coming our way are enormous.

As with almost everything, it all comes down to risk and the

desire to give it away. As we automate a process, we remove some of the human interaction. This procedure can be small, like using a vacuum cleaner instead of a rug-beater, or it can be huge, like using computers to process tax returns at the IRS. When it comes to our health, we are reticent to relinquish care to a process, preferring instead to keep a person in the loop. We are also hesitant to take on the responsibility ourselves by administering self-diagnostic tests. The reasons for this are obvious: if we are wrong about our health, if that persistent sore throat is not allergies but is instead stage one throat cancer, the consequences of misdiagnosis can be devastating. Our goal in healthcare is to eliminate the risk of being wrong, and part of this is handing that risk to a trusted professional, not a machine, a checklist, or a computer.

So far, we have been able to pay for this level of care, demanding a very high level of attention for whatever ails us—a full medical doctor to examine an ear infection, for example—but these days are waning fast. With the aging of the Boomers and the cracks in the healthcare system turning into chasms, we must embrace change to ease the burdens that are on the system today and to prepare for the overwhelming number of users that will be entering the system in the years to come.

¹ Havighurst, Clark C. *Health Care Choices*. Washington, DC: The AEI Press, 1995.

² Berenson, Alex. "Pinning Down The Money Value of a Person's Life," *New York Times*, June 11, 2007.

³ Gist, John and Carlos Figueiredo. "In Their Dreams: What Will Boomers Inherit?" AARP Public Policy Institute.

⁴ Garret, Laurie. "The Challenge of Global Health," *Foreign Affairs*, January/February 2007.

⁵ Bach, Peter B. "How Many Doctors Does it Take to Treat a Patient," *Wall Street Journal*, June 21, 2007.

⁶ Finkelstein, Amy. "The Cost of Coverage," *Wall Street Journal*, February 28, 2007.

⁷ Warner, Joan. "What's Next For Medicare," *Financial Planning*, April 2007.

⁸ Berenson, Alex. "Perverse Incentives Limit Any Savings In Treating Cancer," *New York Times*, June 12, 2007.

⁹ Pauly, Mark. *Health Benefits at Work*. Ann Arbor, MI: The University of Michigan Press, 1997.

¹⁰ Shiels, John, and Haught, Randall. "The Cost of Tax-Exempt Health Benefits in 2004." *Health Affairs Web Exclusives*. February 25, 2004.

¹¹ Havighurst, Clark C. *Health Care Choices*. Washington, DC: The AEI Press, 1995.

¹² Richman, Barak D., "Behavioral Economics and Health Policy: Understanding Medicaid's Failure." *Cornell Law Review*, Vol 90:705, 2005.

¹³ McCaughey, Betsy. "Health Questions for the Candidates," *Wall Street Journal*, February 20, 2008.

¹⁴ Sack, Kevin. "Eligible for Health Insurance, Many Families Have no Idea." *New York Times*, August 22, 2007.

¹⁵ Tanner, Michael. "Lessons from the Fall of RomneyCare." *Cato Policy Report*, January/February 2008.

¹⁶ Ibid.

¹⁷ Dalmia, Shikha. "Saying No to CoerciveCare," *Wall Street Journal*, January 31, 2008.

¹⁸ Lohr, Steve. "Dr. Google and Dr. Microsoft,"