HEALTH CARE NOTES and RESOURCES

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A Commonwealth Fund report (OCTOBER 2015)

analysis shows that in the U.S., which spent an average of $9,086 per person annually, life expectancy was 78.8 years.

Switzerland, the second-highest-spending country, spent $6,325 per person and had a life expectancy of 82.9 years.

The report compares health care spending, use of services, prices, and health outcomes in the U.S. with those in Australia, Canada, Denmark, France, Germany, Japan, the Netherlands, New Zealand, Norway, Sweden, Switzerland, and the United Kingdom. Most of the data are for 2013, and so predate the major insurance provisions of the Affordable Care Act.

Commonwealth Fund researchers found the U.S. to be a substantial outlier when it comes to health spending. Health care consumed 17.1 percent of the nation's gross domestic product (GDP) in 2013, about 50 percent more than any other country.

Despite being the only country in the study without universal health care coverage, government spending on health care in the U.S.—mainly for Medicare and Medicaid—was high as well, at $4,197 per person in 2013.

By comparison, the U.K., where all residents are covered by the National Health Service, spent $2,802 per person.

Americans Get Less Health Care, Spend More for It

According to the study, health care spending per person is highest in the U.S. not because Americans go to doctors and hospitals more often, but because of greater use of medical technology and health care prices that are higher than in other nations. When looking at health service pricing and use, the report finds:

People in the U.S. visit doctors an average of four times per year; only residents of Switzerland, New Zealand, and Sweden have fewer visits. Americans also go to the hospital relatively infrequently, with 126 visits per every 1,000 people, compared to 252 visits in Germany, where the rate is highest.

Americans receive the most diagnostic imaging exams, including MRIs, CT scans, PET exams. The average U.S. adult also takes more prescription drugs than adults in all the other countries except New Zealand.

Prescription drugs are most expensive in the U.S., with prices twice as high as in the U.K., Australia, and Canada.

Prices for health services are considerably higher in the U.S. than elsewhere. On average, heart bypass surgery costs $75,345 in the U.S., compared to $15,742 in the Netherlands, where the procedure is least expensive.

U.S. spends the least on social services. The U.S. spends only 9 percent of GDP on social services like disability benefits or employment programs. It is the only country studied where health care spending accounts for a greater share of GDP than social services spending. In contrast, France and Sweden spent 21 percent of GDP on social services.

High health spending in the U.S. has far-reaching economic consequences, affecting wages and personal financial well-being while worsening budget deficits

National Health Expenditures 2015 Highlights

In 2015, U.S. health care spending increased 5.8 percent to reach $3.2 trillion, or $9,990 per person. The coverage expansion that began in 2014 as a result of the Affordable Care Act continued to have an impact on the growth of health care spending in 2015. Additionally, faster growth in total health care spending in 2015 was driven by stronger growth in spending for private health insurance, hospital care, physician and clinical services, and the

continued strong growth in Medicaid and retail prescription drug spending.
Lastly, the overall share of the U.S. economy devoted to health care spending was 17.8 percent in 2015, up from 17.4 percent in 2014.

Health Spending by Type of Service or Product:

Hospital Care (32 percent share): Spending for hospital care increased 5.6 percent to $1.0 trillion in 2015 compared to 4.6 percent growth in 2014. The faster growth in 2015 was driven by continued growth in non-price factors such as the use and intensity of services. However, hospital price growth was just 0.9 percent in 2015, which was the lowest rate of growth since 1998. Hospital services, from a payer perspective, experienced faster growth in Medicaid and private health insurance spending; however, this strong growth was slightly offset by slower growth in Medicare hospital spending.

Physician and Clinical Services (20 percent share):

Spending on physician and clinical services increased 6.3 percent in 2015 to $634.9 billion. This was an acceleration from growth of 4.8 percent in 2014 and was the first time since 2005 that the growth rate exceeded 6.0 percent. As with hospitals, the faster growth in overall physician and clinical services spending was driven by continued growth in non-price factors.

Price growth for physician and clinical services, however, declined 1.1 percent in 2015, driven by the expiration of temporary increases in Medicaid payments to primary care physicians.

Other Professional Services (3 percent share):

Spending for other professional services reached $87.7 billion in 2015, an increase of 5.9 percent and an acceleration from growth of 5.1 percent in 2014. Spending in this category includes establishments of independent health practitioners (except physicians and dentists) that primarily provide services such as physical therapy, optometry, podiatry, or chiropractic medicine.

Dental Services (4 percent share):

Spending for dental services increased 4.2 percent in 2015 to $117.5 billion, which was an acceleration from 2.4 percent growth in 2014. Out-of-pocket spending for dental services (which accounted for 40 percent of dental spending) increased 1.8 percent in 2015 after increasing 0.8 percent in 2014. Private health insurance (which accounted for 47 percent of dental spending) increased 3.0 percent in 2015 following 2.1 percent growth in 2014.

Other Health, Residential, and Personal Care Services (5 percent share):

Spending associated with other health, residential, and personal care services grew 7.8 percent in 2015 to $163.3 billion after increasing 5.0 percent in 2014. The robust growth was driven by 10.0 percent growth in Medicaid spending, which represented nearly 57 percent of all spending in this category. This category includes expenditures for medical services that are generally delivered by providers in non-traditional settings such as schools, community centers, and the workplace; as well as by ambulance providers and residential mental health and substance abuse facilities.

Home Health Care (3 percent share):

Spending growth for freestanding home health care agencies accelerated in 2015, increasing 6.3 percent to $88.8 billion following growth of 4.5 percent in 2014. Stronger growth in both Medicare (2.6 percent) and Medicaid (6.0 percent) spending -- the two largest payers which accounted for 76 percent of home health spending -- along with faster growth in private health insurance and out-of-pocket spending drove the overall acceleration in 2015.

Nursing Care Facilities and Continuing Care Retirement Communities (5 percent share):

Spending for freestanding nursing care facilities and continuing care retirement communities increased 2.7 percent in 2015 to $156.8 billion. The slightly faster growth in 2015 (from 2.3 percent growth in 2014) was mainly due to the faster growth in Medicare spending of 5.6 percent versus 2.5 percent in 2014.

Durable Medical Equipment (2 percent share):

Retail spending for durable medical equipment, which includes items such as contact lenses, eyeglasses and hearing aids, reached $48.5 billion in 2015, and increased 3.9 percent, slightly faster than the 3.5 percent growth in 2014.

Prescription Drugs (10 percent share):

Retail prescription drug spending decelerated in 2015, increasing 9.0 percent to $324.6 billion. Although growth in 2015 was slower than the 12.4 percent growth in 2014, spending on prescription drugs outpaced all other services in 2015. The strong spending growth for prescription drugs is attributed to the increased spending on new medicines, price growth for existing brand name drugs, increased spending on generics, and fewer expensive blockbuster drugs going off-patent.

Other Non-durable Medical Products (2 percent share):

Retail spending for other non-durable medical products, such as over-the-counter medicines, medical instruments, and surgical dressings, grew 3.7 percent to $59.0 billion in 2015.

Health Spending by Major Sources of Funds:

Medicare (20 percent share):

Medicare spending grew 4.5 percent to $646.2 billion in 2015, which was a slight deceleration from the 4.8 growth percent in 2014. The slightly slower growth in 2015 was largely attributable to slower growth in Medicare enrollment, which increased 2.7 percent to 54.3 million beneficiaries following 3.1 percent growth in 2014.

Medicaid (17 percent share):

Total Medicaid spending slowed slightly in 2015 to 9.7 percent, but continued the strong growth that began in 2014 (11.6 percent) State and local Medicaid expenditures grew 4.9 percent while Federal Medicaid expenditures increased 12.6 percent in 2015. The increased spending by the federal government was largely driven by newly eligible enrollees under the ACA, which were fully financed by the federal government.

Private Health Insurance (33 percent share):

Total private health insurance expenditures increased 7.2 percent to $1.1 trillion in 2015, faster than the 5.8 percent growth in 2014. The acceleration in 2015 was driven by increased enrollment and strong growth in benefit spending.

Out-of-Pocket (11 percent share):

Out-of-pocket spending grew 2.6 percent in 2015 to $338.1 billion, slightly faster than the growth of 1.4 percent in 2014. The increase in 2015 was influenced by the expansion of insurance coverage and the corresponding drop in the number of individuals without health insurance.

Health Spending by Type of Sponsor:

In 2015, the federal government accounted for the largest share of health care spending (29 percent), followed by households (28 percent), private businesses (20 percent), and state and local governments (17 percent).

Federal government spending on health increased 8.9 percent in 2015 after growing 11.0 percent in 2014, and outpaced all other sponsors of health care in both years. In 2015, the federal government was the largest sponsor of health care at 29 percent, up from 28 percent in 2014 and 26 percent in 2013. The main driver for the increased federal share of health care was the continued enrollment of newly eligible adults into Medicaid, who were fully financed by the federal government.

Health spending by households grew at a rate of 4.7 percent, which was an acceleration from 2.6 percent in 2014. Household spending accounted for 28 percent of health care spending in 2015, unchanged from the year before. The faster growth in spending by households was driven largely by households' contributions to employer-sponsored private insurance premiums.

State and local government spending increased 4.6 percent in 2015 compared to 3.2 percent growth in 2014. The acceleration was largely driven by faster growth in state and local Medicaid spending which resulted from increased reimbursement rates and an increased effort to expand care in the home and community setting. Overall, state and local government health care spending represented 17 percent of total health care spending in both 2014 and 2015.

Health care spending financed by private businesses accelerated slightly, increasing 5.3 percent in 2015 compared to 4.7 percent growth in 2014. The private business share of overall health spending has remained fairly steady since 2010, at about 20 percent.

***Type of sponsor is defined as the entity that is ultimately responsible for financing the health care bill, such as private businesses, households, and governments. These sponsors pay health insurance premiums and out-of-pocket costs, or finance health care through dedicated taxes and/or general revenues**

GENERAL COMMENTS

Is more choice always better? When it comes to health care, the answer is often no. What people want isn't choice in medical care, but security. They want to know that when they get sick or suffer an injury they will be able to see a doctor, get medicine, be admitted to a hospital, and receive necessary treatment. They'd also like access to enough preventive care that medical problems can be detected and treated before they become life-threatening. And they would prefer to have all of this without the fear that they'll be bankrupted by the bills.

There is another way — a single-payer system in which access to health care is open to all comers. In such a system, everyone pays in, and everyone is eligible for benefits. Choice has nothing to do with it.

The solution to America's health-care woes isn't more choice; it's less.

Health care may not be a human right, but the lack of universal health coverage in a wealthy democracy is a severe, unjustifiable, and unnecessary human wrong.

In that third week in March in 2010, America committed itself for the first time to the principle of universal (or near universal) health-care coverage(I.E. ACA or OBAMACARE). That principle has had seven years to work its way into American life and into the public sense of right and wrong. It's not yet unanimously accepted. But it's accepted by enough voters—and especially by enough Republican voters—to render impossible the seven-year Republican vision of

removing that coverage from those who have gained it under the Affordable Care Act.

How generous should health coverage be? What should be done to control costs? Who should pay, and on what terms? To what extent should citizens be free to impose the cost of their unhealthy choices upon others?

As Americans lift this worry from their fellow citizens, they'll discover that they have addressed some other important problems too. They'll find that they have removed one of the most important barriers to entrepreneurship, because people with bright ideas will fear less to quit the jobs through which they get their health care. They'll find they have improved the troubled lives of the white working class succumbing at earlier ages from preventable deaths of despair. They'll find that they have equalized the life chances of Americans of different races. They'll find that they have discouraged workplace discrimination against women, older Americans, the disabled, and other employees with higher expected health-care costs.

They'll find that their people become less alienated from a country that has overcome at least one of the least attractive manifestations of American exceptionalism—and joined the rest of the civilized world in ameliorating and alleviating our common human vulnerability to illness and pain.

Medicare is very popular,

Start with single-payer for all during the next bite at the health-care apple, and you could end up with a plan of combining Medicare and Medicaid, enrolling all people under 26 and over 55, and putting a Medicare buy-in on the ObamaCare exchange

Medicare for all is simple, easy to understand, and hard to argue against or distort. Most people know someone on Medicare who can testify to the generally good care, or who is counting the days until they can enroll and have the peace of mind that comes with quality coverage.

The ACA was unpopular in large part because millions of Americans think the state should be doing *more* rather than less. Yet there are a number of important questions about any single-payer plan that remain not just unanswered, but mostly unasked. Democrats need to learn the right lessons here.

What does the transition period look like between the passage of such legislation and its full implementation? What would happen to the health insurance companies that employ over half a million people? Would they be compensated for their losses? What would happen to the medical debt of doctors who would almost certainly face diminished economic prospects under single-payer?

(Most Americans think physicians are rich — true in some cases — yet many doctors rack up over $200,000 in debt to attend medical school.)

Health-care is a giant sector of the economy, but also a delicate ecosystem. And the areas of greatest need in our system — for instance, primary care doctors and rural areas — generally pay the worst and already have trouble attracting physicians for that

very reason. What happens to the supply and demand of care when tens of thousands of doctors earn less?

Do we have even remotely the civilian bureaucratic know-how we would need to scale Medicare up to the entire 320-million-strong population of the United States? The Centers For Medicare and Medicaid Services employ more than 6,000 people. That number would probably need to be, conservatively, quadrupled.

Running a nationalized health-care system would be considerably more complicated than cutting monthly Social Security checks to people.

Remember what happens when various stakeholders in existing, complex, and flawed processes realize that their interests are deeply threatened.

The maximal version of "Medicare for all" would involve, in a quite literal sense, stripping hundreds of millions of people of their existing private insurance coverage — and thus also their expectations about the timing, expense, and reliability of their medical care. Navigating the insurance bureaucracy is frustrating even in the best of times, at the end of the day a significant percentage of the public is likely to react vehemently to any attempt at wholesale, radical change.

Supporters must do the kind of legislative preparation, messaging outreach, and hard. They might just find that

improving the ACA rather than replacing it with an entirely new system would be not just the best policy option, but also the only one that is possible.

"Pharmacy benefit managers," or PBMs,. These middleman companies are a major part of why American drug prices are so wildly out of line with the rest of the world.

The PBMs were rolled up into three big companies — ExpressScripts, CVS Caremark, and OptumRx, which now control a combined 75 to 80 percent of the market. As a result, the promised savings have not materialized. On the contrary, spending on prescription drugs exploded by 1,100 percent between 1987 and 2014, and all three companies — which are each among the top 22 of the Fortune 500 — rake in huge profits. Dayen reports that ExpressScripts' adjusted profit per prescription has increased by 500 percent since 2003.

The repeal effort's biggest hurdle may have been loss aversion, one of the most robust findings in behavioral science. As numerous studies have shown, the pain of losing something you already have is much greater than the pleasure of having gained it in the first place.

Part of the appeal of Medicare for all is that single-payer systems reduce financial incentives that generate waste and abuse. Mr. Ryan insisted that by relegating health care to private insurers, competition would lead to lower prices and higher quality.

Economic theory tells us that this is a reasonable expectation when certain conditions are met. A crucial one is that buyers must be able to compare the quality of offerings of different sellers. In practice, however, people have little knowledge of the

treatment options for the various maladies they might suffer, and policy language describing insurance coverage is notoriously complex and technical. Consumers simply cannot make informed quality comparisons in this industry.

Consider, too, the mutually offsetting expenditures on competitive advertising and other promotional efforts of private insurers, which can exceed 15 percent of total revenue. Single-payer plans like Medicare spend nothing on competitive advertising (although here, also, we see such expenditures by supplemental insurers).

According to the Kaiser Family Foundation, administrative costs in Medicare are only about 2 percent of total operating expenditures, less than one-sixth of the rate estimated for the private insurance industry. This difference does not mean that private insurers are evil. It's a simple consequence of a difference in the relevant economic incentives.

American health care outlays per capita in 2015 were more than twice the average of those in the 35 advanced countries that make up the Organization for Economic Cooperation and Development. Yet despite that spending difference, the system in the United States delivers significantly less favorable outcomes on measures like longevity and the incidence of chronic illness.

The United States spends so much more. The main difference is that prices for medical services are so much lower in other countries. In France, for example, a magnetic resonance imaging exam costs $363, on average, compared with $1,121 in the United States; an appendectomy is $4,463 in France, versus $13,851 in America. These differences stem largely from the fact that single payers — which is to say, governments — are typically able to negotiate more favorable terms with service providers.

People would of course be free to supplement their public coverage with private insurance, as they now do in most other countries with single-payer systems, and as many older Americans do with Medicare.

INTERESTING FACTOIDS

Medicaid facts:

● It is the nation's largest health insurance program by beneficiaries, with 68 million recipients compared with Medicare's 55 million. (Medicare provides insurance for the 65 and over population.)

● Medicaid's costs are shared between the federal government (roughly 60 percent) and state governments (40 percent). In 2015, Medicaid spending totaled $545 billion compared with Medicare's $646 billion.

But the most significant Medicaid fact is this: Although three-quarters of Medicaid recipients are either children or young adults, they account for only *one-third of costs*. The elderly and disabled constitute the other one-quarter of recipients, but they represent *two-thirds of costs*.

How could this be? Doesn't Medicare — not Medicaid — cover the elderly and disabled? Well, yes, but there's a giant omission: nursing home and other long-term care. Medicaid covers these for the poor elderly and disabled.

From 2015 to 2030, the number of Americans 85 and older will rise about 50 percent to 9 million, projects the Census Bureau. Many will end up in nursing homes, with high costs. The average health

costs of Americans 85 and over are 2.5 times greater than for people 65 to 74
Medicaid now claims nearly one-fifth of states' general revenues

The average hip replacement in the U.S. costs $40,364; in Spain, $7,731. In the U.S., an angiogram is $914; in Canada, it's $35.

Lipitor costs $124 per month here, and $6 in New Zealand.

Novartis charged $4500 for month supply of leukemia drug Gleevec; now more than $8500. In Europe drug prices are 50% below USA.

This is the elephant in the room. To address it, and to make health care truly available to all, would require radical change.

31.5 MRI machines /million people vs 5.9/ million in the U.K.
USA healthcare bill in 2014 was $3 trillion or more than next 10 biggest spenders combined.

We spend $17 billion on artificial knees and hips; $86 billion on treating back pain.

1.5 million people work in health insurance industry vs 750,000 doctors.

Specialists earn 2-4X what primary care physicians make.

More specialists means more tests and more expensive care. A MOHS dermatologist earned $586K in 2010-more than a cardiac surgeon.

Medical school is expensive- student debt of more than $150K. Also malpractice premiums of $100k per year.

In Germany dermatologist paid $30 for full body check and $40 for a standard biopsy.

Healthcare industry spends 4X as much on lobbying as the number two beltway spender- the military-industrial complex.

60% of nearly 1 million annual personal bankruptcies resulted from medical bills.

Is health care a commodity like any other, which you can either afford or cannot?

Or is it like education, electricity, or police and fire protection — basic necessities that government should ensure that everyone gets?

We can't decide. Our system is a clunky, free-market/socialist hybrid that ties coverage to employment, age, and income, with tens of millions of people falling through the gaps.

Meanwhile, doctors, hospitals, insurers, drug companies, medical device makers, and malpractice lawyers strive to make as much money as possible tending to the sick.

American Health Care Myths

by PASCAL-EMMANUEL GOBRY

The major impediment to American health care policymakers learning from foreign examples is a raft full of destructive myths. Before anything useful can be done by way of adapting best practices from abroad, Americans must be liberated from these myths.

Myth 1: Universal coverage = socialized medicine.

A common and frustrating feature of the U.S. public policy debate is that the Left will call attention to a fact X, and then assert that this fact requires policy response Y. The Right, instead of contesting the second part of the argument—that fact X necessitates policy response Y—will instead contest the notion that X is a fact.

So, for example, a frustrating number of right-wing politicians, instead of questioning whether a global regime of carbon taxation might have more costs than benefits as a response to global warming, will instead question whether global warming is, in fact, actually occurring.

In health care, one version of this phenomenon is the assumption that universal health care coverage requires a government takeover of the health care sector. Because the Left has a benign view of government and a laudable urge to help out the uninsured, it will call for such a takeover. Instead of questioning whether the laudable goal of universal coverage might be accomplished without a government takeover of health care, the Right will argue against the principle of universal coverage itself. As Singapore and other countries show, this is a false choice.

Myth 2: The United States has a free-market health care system.

This is a very pernicious myth and, again, it prospers because the Right grants the Left's premise. "The United States has a free-market health care system—and look at the mess we're in!" the Left crows. "The United States has a free-market health care system—*and it is the best in the whole wide world! USA! USA!*" the Right responds.

This could not be further from the truth: Look at Singapore, itself hardly a free-market utopia. But more facts should be noted.

First, nearly *half* of health care spending in the United States comes from the government, a figure that is sure to rise as Obamacare implementation continues, and a figure that is much, much higher than that in putatively "socialized" systems like those of Germany, Japan, and Switzerland.

And this does not take into account the biggest "tax expenditure" in the American tax code: the tax deduction for employer-provided health care insurance. Macroeconomically speaking, such tax breaks are government spending—spending directed by the government even if not actually undertaken by the government.

Second, the U.S. health care system is in fact highly regulated. Insurance companies must comply with countless mandates, depending on circumstances, such as "guaranteed issue" (granting insurance regardless of preexisting conditions) and "community rating" (a ratio between the lowest price charged and the highest price charged, which works out to a subsidy of the unhealthy by the healthy, who must pay more for their coverage). And this doesn't get into issues like professional licensing.

Regardless of the merits of such regulations, a sector in which at least half of the spending is directed by the government and the rest is highly regulated is not a "free market" in any meaningful sense of the term. If anything, Obamacare has had the benefit of laying bare the mental model the Obama Administration employs when it thinks about health care insurance: *as a regulated utility*.

Private companies provide the service, but they do so only at the prices set by the government, according to the government's requirements, and with government subsidies. Again, a regulated utility system may or may not be a good idea for health care provision, but it is not a free market.

Myth 3: "Health care = "insurance"; "insurance" = "comprehensive insurance."

What a revealing turn of phrase is to be found in sentences like: "Do you have health care?" and "Everybody in the United States should have health care" and "You shouldn't be denied health care just because you have a preexisting condition." In each of these sentences, it will be obvious to any American that what is being called "health care" is actually "health care insurance." This is so obvious that no one gives it a second thought—yet what is needed is a first thought.

These phrases propagate falsehoods—for example, the claim that the debate in the United States over the past five or six years has been about health care, when it has only been about how to pay for health care. None of the key factors explaining rising costs and poor outcomes has even been touched in legislation.

Furthermore, "health care" does not just mean "health care insurance" but "*comprehensive* health care insurance." That is to say, when someone advertises a job that "has health care", what will be understood is that the employee will be enrolled in an insurance plan whereby, perhaps with nominal co-pays, almost all procedures, even routine ones, will be principally paid for by the insurer.

Nobody stops to notice the self-evident fact that *health care* and *insurance* are two different concepts; the word *health care* means the provision of health care services. After all, we do not ask "Do you drive?" when we mean "Do you have car insurance?" It might be very desirable—indeed mandatory—to have car insurance, but we still recognize that "driving a car" and "having car insurance" are not identical concepts.

Neither does anyone stop to notice that the way health care insurance is conceived of in America is different from all other concepts of insurance. Car insurance typically does not pay for fill-ups at the gas station and routine repairs. Your homeowner's insurance will not pay for the electrician to come change a light fixture. In health care, this is known as "*catastrophic* insurance", a pleonasm, since the very concept of insurance refers to protection against low-probability, high-cost events, namely, catastrophes. Your house insurance pays out if your house goes up in flames or if a huge tree branch breaks off in a storm and crashes into your roof, not if it needs a new paint job. This may all sound pedantic, but it is not: How can Americans even begin talking productively about something if words do not mean what they mean?

If insurance is not necessary for most health care decisions, how do you even begin to explain that you can have health care without insurance to someone for whom the words "health care" and "insurance" are synonymous?

Myth 4: Technology is expensive.

One thing everyone agrees on: U.S. health care spending is rising at an alarming rate. This is typically blamed on improving technology. To most people, this makes intuitive sense, until one realizes that *in every other sector of the economy*, technology gets *cheaper* even as it gets better.

Computers are a well-known example of this phenomenon, but lest you think this an idiosyncratic artifact of Moore's Law, compare a car today with its 1950s-era counterpart: You'll find high-tech equipment, better security features, GPS, air-conditioning, multiple cup-holders, and so on. In terms of purchasing power, today's cars are much cheaper than the 1950s equivalents were for a 1950s buyer. But wait: There is another sector of the economy in which technology only gets more expensive as it gets better: defense. What do defense and health care have in common? (Hint: Myth 2.)
Think of Narayana Health, or of Amazon or Apple for that matter, on the one hand, and the extravagantly expensive and delayed F-35 project, on the other. Which one does the U.S. health system more closely resemble?

Myth 5: Health care is unlike any other good or service.

Every previous myth is really a consequence of this myth. The thing almost everyone agrees on is that health care is special, unlike every other good or service, and therefore the rules that apply to every other good or service do not apply to health care. Health care is different, and therefore government must run it. Health care is different, so of course a "free market", as we see in America (and which does not exist), will be a disaster. Health care is different, so it cannot be insured the way everything else is insured. Health care is different, so of course technology gets more expensive as it gets better. Health care is different, so of course people cannot make their own decisions.

This myth might be called "Arrowism", after the Nobel Prize-winning economist Kenneth Arrow, whose ten-page 1963 paper "Uncertainty and the Welfare Economics of Medical Care"summarized this view, and is routinely trotted out as

"evidence" for the myth. Never mind that the paper does not actually contain anything that could be called "evidence"—that is, observations gained as the result of experiments. Never mind that we do not typically base wide-ranging policies for other high-tech sectors on theoretical papers written in the 1960s.

This isn't to say that there *aren't* differences. First, it is different in the sense that retail is different from automotive is different from mining. Second, it is different because industrialized societies share a number of moral intuitions about health care and who should have access to it—*good* moral intuitions, in my view. This means that at least some government involvement in health care will always be unavoidable, in a way that is not true for retail.

That being said, while there is no room here for a full treatment of this point, the most subversive truth about health care, as David Goldhill convincingly argued in his book *Catastrophic Care*(2013), is that it is more like every other sector than it is unlike them.

We all instantly recognize that it would be a disaster if we collectively decided that the way all cars should be purchased would be by having a job with a company that will provide you a car (with a tax break, and if you lose your job, you lose your car), and an insurer that will pay for gas and oil. Should you not be able to get a car that way, the government will buy you a car. We can easily imagine that, because the choices in the car sector would no longer be made by individual consumers but by powerful entities—the government, large companies, insurers—almost every car would be a hideous, hideously expensive, comically ill-designed clunker akin to the ones that became the butt of "Lada" jokes in the Soviet Union. Or consider what would happen if housing were provided the way we "provide" health care; the mere thought should send chills down one's spine.

But whenever we talk about health care, that part of our brain seemingly shuts off, and these simple truths become about as intelligible as an angry Klingon warrior.

Myth 6: Health care is always good for you.

This might be the most subversive untruth of all. What could be better than health care? Well, *health*, for starters. We agree that health care is a means to an end, not an end in itself, right? And yet, in most U.S. policy debates, health care is discussed as if it were an end in itself.

This is partly because to talk about health instead of health care would broaden the debate to lifestyle choices Americans make that shorten their lives. If politicians were honest, they might say: "The best thing you can do for your health is to stop eating so darn much, fatso, and also drive less and make sure your guns are properly locked up." Not exactly a winning political ad. "Vote for me and *you'll have health care*" is, strictly speaking, nonsense, but it does get votes.

As the economist Robin Hanson wrote, "It has long been nearly a consensus among those who have reviewed the relevant studies that differences in aggregate medical spending show little relation to differences in health, compared to other factors like exercise or diet."[1] Depending on which definition of waste one accepts, we are talking about at least $1 trillion per year and as much as $5 trillion. The RAND Health Insurance Experiment is infamous for showing that families that had easy access to health care consumed a lot more of it, but did not show better health outcomes. This finding was replicated by the recent Oregon Medicaid study. (Both these studies are randomized, controlled studies—the gold standard for evidence in social science.)

Getting a medical procedure you don't need is not just a waste of money and time, it is also, in many cases, positively dangerous. Virtually every medical procedure carries some risk. Those risks may be minute at the level of the individual, but at the level of the system they work out to unnecessary suffering and death on a large scale.

The CDC estimates that 1.7 million people per year, or close to 10 percent of everyone who goes to a hospital (read that again), catch a nosocomial, or hospital-acquired, infection, leading to

close to 100,000 deaths per year. It is almost certain that many of those people who died because they went into a hospital shouldn't have gone in to begin with. Hospitals are very dangerous places to be—particularly if you are sick.

Overuse of antibiotics, too, has led to the emergence of antibiotic-resistant "superbugs", which might be the most potentially scary health care issue of the 21st century. Almost all of the astonishing increases in health over the 20th century are basically due to antibiotics. If antibiotics stop working, the good bet is that most of us will die of some now-harmless disease before we get to try the amazing new cancer treatments that are being invented as I write this.

For health care waste, the Left will blame greedy insurers; the Right will blame government mandates or trial lawyers, whose depredations are thought to cause doctors to prescribe useless tests. But in reality, everyone is to blame, starting with you and me.

Imagine yourself cradling your feverish, sickly, trembling child. You may know in theory about the antibiotic resistance problem, but at that moment you will do everything you can to have your child pumped full of all the antibiotics in the world, even though the best thing for the child is probably to just lie in bed for a few days and drink lots of fluid.
To be sick is to be powerless, in more ways than one, and there is nothing we dislike more than feeling powerless, so we do everything we can, including the counterproductive, to feel less powerless. Like the Romans offering a sacrifice to obtain a blessing, and with about the same evidentiary basis, we order all the medical procedures we can in order to distract ourselves from our fundamental powerlessness in the face of disease and death.

What can we learn from all this? The examples of the free-for-alls of 19th-century America, sub-Saharan Africa, and India, and of the well-tended garden of Singapore, all point to one conclusion: The more that individual health care consumers are in charge of their own decisions, the better off everyone will be. This is not about

“free market” versus “big government.” Someone who has no money, no health insurance, and no help is not in charge of his or her health care decisions. It is very legitimate for the government to give cash to those who need it for medical expenses.

But the crucial insight is that the more third parties are involved in making health decisions for individuals, whether government bureaucrats or insurance bureaucrats or medical bureaucrats, the crazier the system will become.

One ray of sunshine might be an involuntary heightening of the contradictions: The structure of the Affordable Care Act, by removing health care decisions even further from consumers, all but ensures that costs will escalate even faster. At some point, most employers in America will only be able to afford catastrophic health insurance for their employees. If and when that irony busts onto the scene, perhaps real consumer dynamics will emerge, and perhaps America will stumble backward into a Singapore-style system. In the meantime, as we wait for this to play out, American myths about health care will prevent any learning from the best that the world has to offer.

If Americans insist on making their own mistakes, well, they will.