



Myths & Realities Pertaining to a Universal Health Care System.

Beliefs “Why we can’t”

Myth 1: The claim: Vermont is hamstrung by Medicare, Medicaid, self-insurance programs, federal laws and federal mandates and cannot possibly enact anything like a universal health care system on its own.

This is a large, sweeping claim. In the final analysis it implies that Vermont cannot control its own destiny as to health care costs and the fate of its health care services. Is it true? Taken as a whole it is not true.

For easier understanding we will break up its constituent claims into Myths A, B, C, D, E and F.

A - A universal health care system is equivalent to a single-payer system.

This is not true. A single-payer need not be a universal health care system. And a universal health care system need not be single-payer. Some of the world’s universal health care systems have more than one payer, most notably Germany which has more than 1000 payers. For a definition of a universal health care system go to [\[click\]](#)

B - Where there is more than one payer in health care there cannot be a global budget.

This is not true. Germany (see above) uses global budgeting. Other nations’ universal health care systems, whether they have one or more payers, employ global budgeting. Global budgeting applies to the health care services. It determines the total amount spent. Payers simply conform to the system’s standards of reimbursement. If a payer stands outside state control, as is the case with Medicare (see below), and if its reimbursement rates are sufficient, as is the case with Medicare, then the state’s system simply conforms to Medicare’s standard rates. There is nothing to prevent this.

C - Medicare stands outside state control.

This is true as far as it goes. The Myth part is this: The existence of Medicare does not block the state from implementing a universal health care system. The two can co-exist. There is nothing to prevent this.

D - Medicaid stands outside of state control.

This is not true. Medicaid is a state-run program using matching federal funds. It must satisfy a set of federal requirements. These refer to benefits which are more generous than Medicare’s package of benefits. Reimbursement rates are in the state’s control. The threshold to qualify for Medicaid is in federal hands, but waivers can, and have been, obtained here in Vermont. None of this stands in the way of Medicaid’s incorporation into a universal health care system.

E - Almost 75% of health care spending stands outside state control and regulation.

This is untrue. To accept it as true you would have to include Medicaid – but see Myth D. In addition, the math is a bit shaky. The most recent official figures available from BISHCA are from 2003. The amount of Medicare health spending was 17.7%. Employer self-insurance plans accounted for 17.9% of the spending. We will get to employer self-insurance plans below, but it’s enough to know they are off limits to state control (see Myth F). Anyway, the total is 35.6% not 75% (and wouldn’t be even if you included Medicaid, but you shouldn’t because it is a mistake to do so).

(For the record: Medicaid is the largest payer. 16.7% of the 2003 population was in Medicaid. That accounted for 25.4% of health care spending. The current figures will be higher. Medicare is the second largest payer. It covered 15% of the population and accounted for 17.7% of total spending. Employer self-insurance plans covered 24.3% and 17.9% of total spending. Private insurance (either through employers or purchased directly) covered 33.9% of the population and accounted for 23.3% of total spending. A little over 10% of Vermonters had no insurance of any kind.

F - The claim is that ERISA law – which prevents tampering with employer self-insurance plans - stands as a barrier to any publicly financed universal health care system as long as employers pay anything into it.

The claim as it stands is untrue. The reason it is untrue is that no one can make this claim. Here is why:

The intent of ERISA (Employee Retirement Income Security Act) is to protect employers from state-mandated benefits, either health or pension. An ERISA case went to the U.S. Supreme Court in 1995. The Court reversed a lower court decision that found New York State in violation of ERISA law. Involved were surcharges placed on hospital rates that were not direct mandates against employers but peripherally involved employer ERISA plans. The Court noted that the intent of ERISA was not to impede states from exercising normal regulatory functions, that these functions were in fact encouraged by other federal policies. But the Court also noted that its reversal was not to be interpreted as barring ERISA enforcement from any but direct conflicts with state laws or regulations.

The gray area between direct and indirect effects, including influences, on employers remains uninterpreted and undecided. No other case bearing on this has been decided.

So the first thing to understand is that it will come down to two things: First, the design of a universal health care system's financing and, secondly, to a battle of experts. Legal experts we've consulted tell us that a universal health care system that finances health care services used by the whole population through public revenues would almost certainly survive an ERISA test.

(For those interested, the 1995 case is *New York State Conference of Blue Cross & Blue Shield Plans, et al., Petitioners, v. Travelers Insurance Company, et al.*, 04/26/1995. In it, New York State had placed surcharges on hospital rates for specified sectors of patients whose insurance or managed health care plans fell under ERISA influence. The question was whether state regulation "pre-empted" ERISA law. The Supreme court wrote: "We acknowledge that a state law might produce such acute, albeit indirect, economic effects, by intent or otherwise, as to force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers, and that such a state law might indeed be pre-empted ... But as we have shown, New York's surcharges do not fall into either category; they affect only indirectly the relative prices of insurance policies, a result no different from myriad state laws in areas traditionally subject to local regulation, which Congress could not possibly have intended to eliminate." The Court also acknowledged that: "...we do not hold today that ERISA pre-empts only direct regulation of ERISA plans...")

Beliefs "Why we shouldn't"

Myth 2: The claim: Health care would be government-run

The inference you're asked to draw is that a universal health care system is tantamount to government's making medical decisions for you. This is untrue. Acquaintance with any of the world's health care systems demonstrates the falsity. Governments in these systems publicly finance their health care. And they conduct oversight at the system level. Patient-level decisions are left to doctors and patients. Decisions within their health ministries, departments or agencies affect health care at the overall, or population, level.

U.S. military hospitals are publicly financed and have public oversight, so do Veterans Administration hospitals. Decisions are left to doctors, not government bureaucrats. Vermont's governor's health insurance - like that of many other elected office holders - is publicly financed. Medical decisions are left to his doctors. It is not "government-run." Health care in Vermont, and the U.S., endures more bureaucratic interference by private insurers than other nations experience from their health system agencies.

Citation: Health Affairs 2001; 20(3)238 Physicians' Views on Quality of Care: A Five Country Comparison.

Myth 3: The claim: We have the best health care in the world, so let's not tinker with it.

This is not true. The World Health Organization released an assessment of health systems throughout the world. Rankings are based on an overall index of performance. The U.S. ranked 37th despite being number one in per capita health care spending. We rank 25th in male life expectancy and 19th in female life expectancy compared with 29 other industrialized countries. These and other overall rankings do not speak highly of the U.S.'s health care compared to other nations. However, at the same time, excellent health care can be obtained in this country. Vermont's health care always ranks high among the states. Still, the rankings

suggest that health care in the U.S. is not consistent nor is it well distributed. Moreover, to classify the U.S.'s as the best "system" in the world ignores the fact that in any one month of the current year the number of Americans with no health coverage - many of them from the working middle-class - reaches 67 million (including 69,000 Vermonters). Even this figure underestimates the problem because large numbers of Americans have been impoverished by health care costs and have been absorbed into Medicaid programs.

Myth 4: The claim: Administrative savings in a Vermont universal health care system would be far less than imagined.

This is a large claim. One of the attractions of a universal health care system is that it holds the potential of very large administrative cost savings. The claim contains several parts and we will divide them for easier grasp into Myths A, B, C, D, and E.

First, some background. America's health care consumes vast sums in administrative expenses. This is not in dispute. Nearly one fourth to one third of every health care dollar goes to administrative expenses. By and large these are necessary expenses as things stand, because of the complexities of medical care charges, payment schedules and collection bureaucracies in the U.S.

Second, other nations' health care systems all have lower administrative costs. This is not in dispute. Even complex systems with many payers are 10 to 15 percentage points less costly than the U.S.

A - Vermont's administrative costs are low, therefore savings will not amount to much.

This is not true. Vermont's administrative expenses run a little more than one quarter of all health care spending – 26% in 2003. This year (2005) overall health care costs for Vermont are \$3.5 billion, so for every 1% reduction in administrative costs we could have saved \$35 million. Vermont's administrative expenses run a little more than one quarter of all health care spending – 26% in 2003. The U.S. average is even higher, 31%.

No experienced manager of large systems or business would tolerate these administrative cost burdens. All other nations' health care systems operate at less than 20% administrative overhead, and even fairly complex systems with many payers, like Germany's, run below 15%. For comparison's sake, the government-operated Medicare program runs at 2% and the government-run Medicaid at 8%. Private insurance companies administrative overhead averages 12-15%.

If Vermont's administrative overhead were to drop to only the high-end of other nations' administrative costs – let's say, to 19% - cost savings this year would have been \$245 million. No other cost-saving proposal for Vermont's health care comes even close to that number.

Citations: The Lewin Group estimated administrative costs at 25% in 2001; a more recent figure from 2003 was 26%, appearing in the International Journal of Health Services Vol. 34, Issue 1, pp 65-78, 2004. "Cost of Health Care Administration in the United States and Canada: Micromanagement, Macro Cost," Woolhandler, Campbell, and Himmelstein. Private insurers national averages appeared in NEJM, 2003, Aug 21, Journal No. 349, Issue 8. The Medicaid number is from 2003, BISHCA. The Medicare number is widely available. Comparison figures from 1990 – the latest available – put the U.S. at 24%, United Kingdom at 16% and Germany at 13%. The comparisons were made by the McKensy Global Institute (cited in "The Public-Private Mix for Health", edited by Alan Maynard, Radcliffe Publishing 2005, p 105).

B - Vermont's administrative expenses look high because they include extraneous items like laundry costs.

The claim is that administrative costs for hospitals, the largest health care sector, are exaggerated. The intent is to cast doubt on potential savings on administrative overhead. This would be true if we used BISHCA data, because it allows inflation of costs with extraneous items like laundry. But we don't use BISHCA data. Our figure of 24.3% for hospital administrative overhead is based on Medicare data. Its accuracy is unquestioned because Medicare has strict rules for reporting hospital costs. It expressly forbids lumping laundry and other such extraneous items under administrative expenses. Medicare also is the largest payer toward Vermont hospital costs.

Citation: The hospital administration figure based on 1999 Medicare data appears in NEJM in 2003, Aug 21, Journal No. 349, Issue 8. The Lewin Report estimated hospital administration at about 33% in 2001, apparently using BISHCA data.

C - A universal health care system in Vermont will necessarily operate with more than one payer, e.g., Medicare, and therefore administrative savings will not amount to much.

This is true up to a point. A single-payer is the most administratively efficient system. This is out of reach for Vermont. Germany is a counter example of a health care system that has hundreds of payers and yet operates at well below 20% administrative overhead. Even a reduction to 20% would reap huge savings for Vermont (see Myth A above). As long as we have an organized system with uniform reimbursements and uniform benefits the presence of more than one payer is not an impediment to administrative cost savings. A Vermont system could easily conform to Medicare's reimbursement schedules, making the system uniform in that respect, and to Medicaid's benefits, making it uniform in that respect. Nothing stands in the way of this.

D - Cross-border issues with New Hampshire and New York State will undermine administrative cost savings.

This is true up to a point. The background is this: 30% of Dartmouth-Hitchcock Medical Center's revenues in New Hampshire come from Vermont patients. 25% of Vermont's health care revenues – largely at Fletcher-Allen Medical Center – come from New York State patients. If a universal health care system were to conform to Medicare rates, Dartmouth-Hitchcock could be counted on to be satisfied. So the cross-border issues in that direction would be of little concern. Of more concern would be New York State patients arriving at Fletcher-Allen and a few other Vermont hospitals bearing different insurances. This would decrease the potential for administrative savings.

This said, it would not decrease it enough to ignore the possible savings. Even a few percentage points decrease is significant. (See Myth A above.) Again, Myth D is advanced as a reason for not doing something. There is some truth to it, but it is not a strong enough reason.

E - A government-created agency of whatever kind is incapable of administrative efficiency.

Needless to say this is untrue and has no basis in fact. It is however a matter of faith among opponents of systematic health care reform. Government-run Medicare operates at 2%, government-run Medicaid runs at 8%. Private insurers run at 12-15%. Vermont's overall health care administrative expenses are 26%. The U.S.'s overall expenses are 31%. (See Myth A above.)

Myth 5: The claim: Taxes will soar.

It is not true taxes would inflate to a shocking figure, say \$2 billion, without a deflation in other taxes and costs. The net cost would be less. The claim is meant to scare away systematic health care reform.

It is true that a publicly financed universal health care system would require state revenues to operate. How much is the important question. Opponents of systematic reform use inflated tax figures to frighten people. Proponents of reform tend to use figures that underestimate the full cost. So let's start at the beginning.

Here's what we know:

We know that taxpayers in the U.S. pay more into health care than taxpayers in other nations with universal health care systems. The third most expensive of the world's health care systems pays a third less in taxes than we do. And that does not include our added out of pocket expenses that nearly equal its tax bill for health care.

We know that a 2001 estimate for Vermont claimed that a 2.9% income increase and a 5.8% employer payroll tax was enough to finance a single-payer system in Vermont. We think those figures are low, but those were the estimates.

There is room for them to be low estimates. Employers, for example, right now on average spend 12-15% of their payroll and health benefits, and that is on top of their Medicare payroll taxes.

We know that the health care bill – the overall spending – is being paid by us in its entirety now. Official figures for 2003 look like this: Our income taxes paid for \$1.4 billion of the health care bill. We paid, our employers paid, our property taxes paid, and some of our income taxes paid for \$1.24 billion of the health care bill through private insurances. We paid out of pocket \$404 million toward the health care bill. All of the total bill (a bit more than \$3 billion in 2003) is paid by us, no matter how circuitous the route.

We know that some of our federal income taxes go into Medicare, some of our state and federal income taxes go into Medicaid, some of our state income taxes help pay public employees health insurance, a large share of our property taxes pay for public employees health insurance, some of our taxes are used to offset tax-forgiveness to employers paying for employees health benefits.

Here's what we don't know:

We don't know what a universal health care system would cost after systematic cost-reduction measures were put in place. All of the cost-efficient measures require a real health care system to implement (e.g., administrative savings).

We don't know the effect on overall spending of rational planning, which again depends on a state-wide health care system. We know that it will save money, but not how much.

We don't know, therefore, how much of an income tax increase would do it, or whether an employer payroll tax would be necessary, and if so, how much.

We don't know the full effect of consolidating a tax package to support health care for everyone and getting rid of other uncoordinated revenues now pouring into health care, namely, property taxes and out of pocket payments. We do know that the per capita cost to Vermonters of consolidated public financing would be less than now.

We don't know the far-reaching, overall effects on the Vermont economy of publicly financing a health care system for everyone.

Here's what we need to know:

We need to know how much it will take in publicly-raised financing to create a universal health care system for Vermont. To do this we need to take into account cost increases and decreases for everyone.

We need to know the broad economic consequences of this – the secondary and ripple effects throughout the state's economy.

Citations: For employer tax burdens, Commonwealth Fund Survey (**Deb is looking up.**) For 1998 the New England Journal of Medicine (1999, 340:109) reported that U.S. per capita tax contributions to health care averaged \$2,700. We also averaged \$1,500 in private and out of pocket expenditures For 1998 the Journal reported the per capita tax cost toward health care in Germany, the world's third most expensive health care system, averaged \$1,800. Tax estimates for single-payer are from The Lewin Group's "Analysis of the Cost and Impact of Universal Health Care Coverage Under a Single-Payer Model for the State of Vermont health care expenditures are from BISHCA (2003) Vermont Health Care Expenditure Analysis and Forecast (March, 2005).

Myth 6: The claim: Rationing will ensue from a universal health care system.

The word rationing is inflammatory (and is meant to be by opponents of universal health care). The dictionary definition is the "egalitarian distribution of scarce resources," but nearly everyone associates it with their being deprived of something they are owed.

We propose the term allocation of resources. Allocation is a rational approach and occurs in advance planning. It takes into account current and projected conditions. Universal health care systems engage in allocation of resources (as do all large business, corporate and public systems). A perfect example of rationing occurred during the 2004-2005 flu

season. Flu shots in the U.S. were rationed. The emergency cause was the unanticipated failure of a United Kingdom supplier. A major contributing cause was poor advance planning or allocation of resources. Canada and other health care systems, including Great Britain itself, that engage in planning and allocation did not experience shortages.

With that said, rationing does not originate in a universal health care system, any more than rationing in U.S. health care is an official policy. So the claim as it stands is not true. What is true is that allocation of resources is a fact of life in all large systems. A deeper problem is that no health care system capable of allocating resources in a rational way exists in Vermont or other states. Rationing here in the U.S. is not based on rational choices or policy. Frequently it is self-imposed and stems from an inability to pay for insurance, to pay deductibles, to pay for co-pays. This is an unofficial, tacit form of rationing that goes unreported and is widespread in the U.S. Because it is unofficial there is no one to take responsibility for the resulting health calamities. Nations with health care systems publicly acknowledge emergency rationing when it occurs and take public responsibility.

Health care is a dynamic social sector. It is assailed by pressures, changes in society, developments inside and outside its own field. It has some built-in flexibility to absorb these stresses and changes. Occasionally they rise to the level of an emergency. The sensible way to cope with this sector's dynamism is rational allocation of resources. It can never be perfect, but it is public, transparent, and responsible.

Myth 7: The claim: In other nations' health care systems the medical care is inferior.

This is not true. See Myth 2 above in this section.

Myth 8 The claim: If we implement a system like theirs we will experience waiting lists.

This is not true. Some universal health care systems have waiting times, some don't. U.S. health care has waiting times. Why would we want to imitate one of the systems that has burdensome waiting times? No one has suggested it. Basically, this is red herring. We are spending more than enough money to buy whatever system we might want.

Here is more on the topic of waiting times: Usually addressed are elective (or non-urgent) surgeries. Waiting times vary in different health care systems. The claim is far too vague and general to be meaningful. Waiting times exist in U.S. health care. Waiting times exist in other systems. The difference between the U.S. and other nations is this: in the U.S. waiting can depend on ability to pay; in other nations waiting can depend on supply of services. If supply of services is increased, waiting times decrease, but overall health care costs increase. Over-supply can be found in the U.S. This can mean short waiting times, if you have the ability to pay, but also explains why we have the highest health care costs in the world.

The balance between supply and demand is something all health care systems must cope with. An important factor to look at it is that publicly-established and financed health care systems, because they owe something to the public, report their own shortcomings and respond to public pressures. U.S. health care does not.

Beliefs about "What we need"

Myth 9: The claim: Enhancing the private insurance market will reduce premium costs.

For clearer understanding we will divide this claim up into Myths A, B and C.

A - The claim: Increasing the number of private insurers will bring down costs.

In 2001, when figures are available, Vermont had more group insurers per population measure than all but nine other states and more individual insurers than all but seven other states. Vermont's per capita health costs were \$4101 in 2001, less than the national average of \$5035. Now, using admittedly rough estimates, of the nine states with more group insurers five had higher per capita costs and four had lower than Vermont. Of the seven states with more individual market insurers four had higher costs and three had lower costs. The evidence – again based on rough estimates – is inconclusive.

The number of insurers is not a clear-cut factor in per capita health care costs. A case can perhaps be made for an adequate number of insurers. But even this is weak. In every state the large insurers control the market. In 2001 on average a single insurer in any state had 39% of the market and the largest three 66%. On average half the remaining insurers in all states controlled no more than 3% of the market. When we look at states with the fewest insurers, we find: Of the bottom five with fewest individual insurers, four had higher and one had lower per capita costs than Vermont. Of the bottom five with fewest group insurers, three had higher costs, one had virtually the same costs and one had lower costs than Vermont. Again, these are based on rough estimates.

The relationship between the number of insurers and costs is not strong enough to draw any firm conclusions. Part of the problem is that per capita costs depend on other factors, some of which are undoubtedly stronger influences on per capita costs than the number of private insurers in the state.

What is not in dispute, however, is that Vermont has consistently ranked among the lowest per capita health care costs in the country regardless of the number of private insurers doing business in the state.

Citations: U.S. Census Bureau, Kaiser Foundation, [article cite.]

B - The claim: More private insurers would mean more competition, which would mean lower costs.

This may sound as if what is meant is that private insurers will compete with each other to reduce the price of their policies. But that's not how it works. Competition in health care means something else. It goes like this: The bulk of insurance payments are made for hospital care. To lower premium prices, insurers have to pay less out, especially to hospitals. To pay less out, insurers must drive down the prices of care. To do this, insurers need a competitive environment. But the competitive environment is not among themselves. It is – and this is the key point – among health care services. This allows insurers to hard bargain with providers over prices of medical care. If they can bargain them down, they can lower premium prices.

The hitch is this. Vermont does not offer a competitive environment among health care services. The conditions necessary for such an environment are hospitals in head to head competition in our towns and cities. We don't have that. We are a state of one-hospital towns and cities. There is no good leverage for insurers to bargain down prices of care.

Vermont is what experts describe as a provider-dominated environment. What insurers prefer is a payer-dominated environment. For that to exist over-supply of health care services is required. Hospitals in that situation fight for patients and fight to get paid. Insurers can play off one against the other, driving down prices for care.

What is wrong with this scenario?

Here may be the place to address a mistake that is common to almost all cost-reduction proposals. Its origins lie in a particular idea. The idea is that if you reduce costs for some one group everyone benefits. Overall costs of health care will go down.

Is this true? In general, we think not. For example, reducing private insurance premiums across the board would benefit the 58.2% of Vermonters who carry private insurance, but not the rest. And even that is not exactly true, because reductions would not come across the board. Still, some of the 58.2% would enjoy lower costs. Would this lower overall health care costs? In the short run, meaning at least a year, the answer is no. The reason for this is important.

Health care services – hospitals, doctors' practices, etc. – make up 70% of health care costs. Of that 70%, right around 84% are fixed costs. Fixed means that on an annual basis or longer they have to be met for the services to operate as they have been. Hospitals are a perfect example. Little of their annual costs are flexible. The figure is only about 16%. So if they are forced into reducing their prices – their charges for care – it isn't going to make any difference to their health care costs for a year or more. To go on as they are, they have to satisfy those fixed costs.

A very good example of just how squeezing down prices does not work as advertised already exists. Medicaid is the largest single payer of care charges in the state. It pays way below what it costs to deliver the service. So in effect it has been forcing down prices presented to it by health care services for years. What has been the effect on health care services? Not much, and what effects have taken place are for the worse not the better. Overall health care costs meantime have gone up not down.

The fact that we have an infrastructure built of health care services must be kept in mind. It is this infrastructure we want to keep going and to keep it going we have to realize an inescapable fact: we Vermonters must somehow see that the fixed costs of this infrastructure are met. This is the basic problem we all face regarding health care. And behind that lies the question: How are we going to share this fiscal burden among ourselves? Are we going to do it fairly or unfairly?

We began by talking about how to reduce insurance premiums. By now it should be clear that that is the wrong focus. Granted, the cost of insurance is what stares us in the face all the time. But behind that stands the all-important factor in health care: the health care services infrastructure. That ought to be the critical focus. Without our shared health care services, health insurance of any kind, of any price, is meaningless.

Is there no merit in cost-saving proposals? There is. But it is limited, depending on the proposal. And almost always the savings are either small or won't kick in for years, even decades. This is all right too, except that those proposing them lead us to believe they are quick fixes for health care costs. They are not.

Finally every cost-saving proposal that does not exhibit system-wide responsibilities to the health care services holds the potential of doing more damage than good in the long run. Cities in other states where the fostering of private insurance competition was touted as a solution to high costs have learned what that really means. It has meant lower premiums. It also has meant hospitals cutting corners, sacrifices in quality of care, it has meant mergers, it has meant closures. What it has not meant is a reduction in overall health care costs.

In any case, Vermont can count itself fortunate. It does not to qualify for this kind of competitive markdown in health care. We don't have what it takes to convince a flock of private insurers that this is where they want to set up shop.

C - The claim: If we got rid community rating, if we made Vermont a private insurer-friendly market, insurers would flock here and premiums would cost less. .

First of all, see Myth B above for the kind of competitive environment needed by insurers to drive down prices.

Would, however, abolishing community rating provide that environment? The answer is No.

Vermont is one of the few states remaining with community rating. Community rating prevents insurers from discriminating among policy buyers. Abolishing it opens the door to what is called cherry picking. And that term refers to insurers discriminating in favor of young, healthy purchasers of insurance and against older, less healthy ones.

The fact is that Vermont's community rating applies to only 10% of the population. It's not enough to change the minds of insurers looking for profitable territory.

Myth 10: The claim: Cost-conscious patients will save money because they will use less.

This sounds true. If you use less, it will cost less. There are two factors to consider before accepting it.

First, the vast majority of medical decisions are in fact made by the doctor, in concert with the patient. The figure is about 90%. It can be higher in the specialties. It is rare for decisions by the patient to be based on cost, as you will recall from your own experiences with medical care. The cynical, but nonetheless largely true, observation here is that people who advance this idea like to talk about other patients' need to be cost-conscious, not their own. The list of possible patient cost-saving choices is not long. The patient might choose generic pharmaceuticals over brand names. Against a physician's best advice, a patient might choose to delay or skip altogether a diagnostic test (a popular candidate for this

among patients is the colonoscopy). The likelihood of ill patients choosing the cheapest available procedure seems small. When it comes to our own health few of us are prepared to associate quality with the cheapest.

The second factor is crucial to understanding health care and cost savings. Most of the costs in health care, at least 70%, are linked to the health care services, such as hospitals, physician practices, etc. And of the costs, 84%, if not higher, are fixed on an annual basis. This means that a few people or even quite a few people declining to use our health care services has no significant impact on the overall costs. If they were to persist in rationing themselves, or shopping for the cheapest care, over the long-term, they might represent a population trend. And that would affect overall health care costs. Population demand affects long-term costs. Short-term population demand has almost no effect. On the other hand, supply is a big factor in costs now and in the future. Costs are little affected by using less health care services (the supply) now. But over the longer run – a year, two years, five years – using less will bring down overall costs.

Citations: “Health Costs Absorb One-Quarter of Economic Growth, 2000 – 2005: Recent Federal Report Unintentionally Obscures Massive Rise, Physicians’ Decisions Key to Controlling Cost” by Sager and Socolar, Feb. 7, 2005.

Myth 11: The claim: If Americans had better health habits costs would be lower.

This is true. But the Myth part is the inference that Americans’ health care habits are worse than average. They are not.

Our health care costs are twice the average per capita in other countries. So, are Americans’ health habits to blame? Are we worse than those in the rest of the industrialized world? The evidence does not support it. Our ranking among nations for general health indicators (life expectancy, infant mortality, etc.) are very low, but our rankings for good health habits are relatively high. The World Health Organization reports that the U.S. ranked 3rd best for men and 5th best for women in tobacco abuse when compared to 25 industrialized countries. (WHO June 2000). We rank fifth best for alcohol consumption. We rank fifth best of 20 countries in animal fat consumption for men 55 to 64 years of age. We rank third best of 13 countries for cholesterol concentration for men 50 to 60 years of age. (JAMA, 7/26/00 - Vol. 284, No. 4: 483)

Myth 12: The claim: Health care costs are high because people demand too much health care

This is not true. Costs are high because we are paying for an array of health care services we all think we may want at some point. Our health care services – call it our health care infrastructure – stands for our supply of health care. Most of its costs are fixed on an annual basis. If we reduce the supply, costs go down; if we increase the supply, costs go up. Decreasing or increasing the supply also affects our health care.

Cost saving measures put forth in health care always take the form of the above. They go like this: If we reduce the use of health care services we can save money. We can reduce the use by educating patients, making them more cost-conscious, steering them away from asking for a lot of health care, getting them to change their health habits, and so on. There is nothing wrong with any of these ideas, except they will not lead to significant cost savings. Over time they may, but over time in this case means years if not decades. They ought to be pursued, and could be pursued if we had a system. Over time they would make a dent in health care costs, not a dramatic dent, but a dent nonetheless

The mistake made is that at least 70% of health care costs are tied up in the health care services, the ones we all want. If we want to directly affect overall health care costs, we have to reduce the amount of health care services. It’s not a question about individuals; it’s a question about what the Vermont population needs and wants. It’s not a question about individual use, but about supply. You’ll notice that whenever one of these individual-use proposals is made it’s about some other person’s use of health care, not the proposer’s use.

That’s the overview. Now as for our actual use of health care here are some facts: Americans visit the doctor less often than people in any other industrialized country except Britain which has a slightly lower rate. (OECD, 1999). We have the lowest rate of hospital stay in the industrialized world and Vermont’s length of hospital stay and rate of admission are consistently below the national average. The Vermont rate of hospitalization has actually been declining steadily from the last known measures in 1994-1998. (OECD, 1999 & Vermont Health Care Quality Report May 2000). In general, Vermonters receive fewer surgical procedures per person than the national average. (Vermont Health Care Quality Report, May 2000). The majority of Americans, over 80 percent, use very little care: an average of about \$700 a year.