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THE HIDDEN COSTS OF HEALTH CARE COST-CUTTING: TOWARD A POSTNEOLIBERAL HEALTH-REFORM AGENDA

FRANK PASQUALE*

I

INTRODUCTION

Neoliberals advocate for “marketization,” but the transition to markets in pervasively regulated fields like health, defense, and education is complex. There is no way out but through. The state itself must capitulate to (and coordinate) its subjects’ purported emancipation from it.¹ Thus a paradox threatens the coherence of the thought of neoliberals. Wealth accumulation up to now, they assert, has been distorted by various ill-considered or malicious state interventions. Reform is imperative. But the past maldistribution of wealth biases the present political playing field: tycoons who won crony capitalist favors in the past are going to use those gains to influence future elections, and in particular the future terms of marketization. So the neoliberal doubles down publicly: as the contemporary political economist of laissez-faire, he insists that legislative, regulatory, and cognitive capture just prove that the state needs to be shrunk. Left un- (or less) spoken are the more critical questions: What parts of the state are to shrink? And what is to be maintained, or grown, as the

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1. PHILIP MIROWSKI, NEVER LET A SERIOUS CRISIS GO TO WASTE: HOW NEOLIBERALISM SURVIVED THE FINANCIAL MELTDOWN 69 (2013). Therein, Mirowski documents the neoliberal pattern of

hav[ing] it both ways: to stridently warn of the perils of expanding purview of state activity *while simultaneously* imagining the strong state of their liking rendered harmless...; to posit their ‘free market’ as an effortless generator and conveyor belt of information *while simultaneously* strenuously and ruthlessly prosecuting a ‘war of ideas’ on the ground; asserting their program would lead to unfettered economic growth and advanced human welfare *while simultaneously* suggesting that no human mind could ever really know any such thing.

Id.

guarantor of a new market order?

Beneath the surface of state versus market rhetoric, the U.S. political economy increasingly features battles between combined state-market *sectors* over their respective shares of profits and power.² As these “battles of the sectors” wear on, one critical player—health care—appears to be on the verge of an unconditional surrender in the marketplace of ideas. The imperative to cut health care costs has become a background assumption in health law and policy. It is something that not just nearly all mainstream economists, but all serious policymakers, whatever their political views, tend to accept as a basic ground of informed discourse. If health care has, as former acting director of the Centers of Medicare & Medicaid Services (CMS) Donald Berwick maintains, a “triple aim” of quality, access, and cost control, it appears that the last imperative is *primus inter pares*.³ Cost-cutting is a standard that liberals and conservatives, libertarians and progressives are eager to rally around. In a policy landscape riddled with irreconcilable differences over fundamental values, cost-cutting is a unifying theme.

The critical question, though, is *how* to cut health care costs. Beneath the superficial consensus that “health care is too expensive,” there are raging debates on strategies of cost containment. Some favor supply-side limits: for example, reducing the quantity or price of providers. Others focus on the demand side: how to reduce expenditures on health care (by, say, removing the tax exemption for employer-provided health insurance or imposing taxes on certain insurance). A growing “quality movement” argues that “pay for performance” will reduce costs by shifting spending to effective interventions, and away from wasteful ones.

How much should our society spend on health care? That is a deep and difficult, political and economic (and fundamentally politico-economic) question.⁴ Yet it ought to be addressed *before* policymakers point to high health care spending *in itself* as a rationale for reducing the purchasing power of patients, reducing compensation of physicians, nurses, and other providers, or deterring investment in hospitals, drugs, and devices.

Even if policymakers frankly accept a health expenditures goal along the lines of “the same percentage of GDP as other advanced industrial economies,” there is critical conceptual work to be done before pursuing it. Before imposing

2. As Grewal and Purdy explain in their introduction to this issue, “The questions that neoliberalism addresses, then, are not ‘how much market,’ or ‘how much governance,’ but which interests will enjoy protection. . . .” David Singh Grewal & Jedediah Purdy, *Introduction: Law and Neoliberalism*, LAW & CONTEMP. PROBS., no. 4, 2014 at 8–9.

3. See Donald M. Berwick, et al., *The Triple Aim: Care, Health, and Cost*, 27 HEALTH AFF. 759, 759–69 (2008).

4. For a definition of political economy and its relevance to law, see Frank Pasquale, *Capital's Offense: Law's Entrenchment of Inequality* (reviewing THOMAS PIKETTY, *CAPITAL IN THE TWENTY-FIRST CENTURY* (2014)), BOUNDARY 2 REVIEW, Oct. 1, 2014, at 2, available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2520251.

blunt instruments of cost containment like vouchers and changed tax treatment of insurance, policymakers need to evaluate which subsectors within the health sector are *undervalued* and which are *overvalued*. It makes little sense to aspire to cut health expenditures *in general*, particularly if those that are now absent, undersupplied, or undercompensated are worth, in the aggregate, more than the waste now being paid for. Far too many policy discussions proceed on the assumption that (1) waste is easy to identify, (2) once identified, there are tools available to deter spending on it, and (3) deterring spending on waste will lead to reallocation of that spending to either worthier health spending, or worthier spending in the economy as a whole. Only on rare occasions do all these assumptions clearly hold.

To develop a more rigorous approach to cost containment, this essay proceeds as follows: Part II examines the fundamental conflict that cost-containment papers over—namely, whether American health expenditure exceptionalism is a result of *inadequate* or *excessive* implementation of marketization and the profit motive. Parts III and IV call for a more textured analysis of health care expenditures to encourage a revaluation of aspects of health care that are now scarce (thanks in part to inadequate compensation for them). Part V concludes with some reflections on how winners of past conflicts on health care governance parlay money into power (and power into money). They have shaped a consensus for cost-cutting while obscuring the many ways their dominance has impeded quality of care and access to medicine and may raise costs in the future.

II

MARKETS AS CURE OR CAUSE OF U.S. HEALTH EXPENDITURE EXCEPTIONALISM?

American health care is uniquely expensive.⁵ For example, U.S. doctors may be overeager to deploy advanced imaging technology. Others spread the blame, lamenting an insufficient evidence base for a surprisingly high percentage of care. In her book *Overtreated*, Shannon Brownlee argues that the U.S. health care system spends “between one fifth and one third of our health care dollars . . . on care that does nothing to improve our health.”⁶ Brownlee’s

5. Jonathan S. Skinner, *The Costly Paradox of Health-Care Technology*, in *Business Reports: A Cure for Health-Care Costs*, MIT TECH. REV. (Sept. 5, 2013), available at <http://www.technologyreview.com/news/518876/the-costly-paradox-of-health-care-technology>.

Unlike many countries, the U.S. pays for nearly any technology (and at nearly any price) without regard to economic value. For this reason, since 1980, health-care spending as a percentage of gross domestic product has grown nearly three times as rapidly in the United States as it has in other developed countries, while the nation has lagged behind in life-expectancy gains.

Id.

6. SHANNON BROWNLEE, *OVERTREATED: WHY TOO MUCH MEDICINE IS MAKING US SICKER AND POORER* 27 (2008).

In the latter part of the twentieth century, dozens of common treatments, including the

careful work builds on health services research that suggests a number of places where American health systems could improve outcomes while cutting costs.

On the other hand, there are certain convenient narratives about American costs that need to be debunked. For example, some scolds claim excess utilization of health care in the United States is driving costs. But Americans do not use more physician or hospital services than, say, the Germans or the French (both nations with significantly lower per capita health expenditures).⁷ Rather, the most significant culprit behind exorbitant health care costs is high prices, not overutilization. As one study showed, the “[p]rice of professional services, drugs and devices, and administrative costs, not demand for services or aging of the population, produced 91 percent of [health care] cost increases since 2000.”⁸ Doctors, hospitals, and pharmaceutical firms all make more money in the United States than in any other comparable country.⁹ Advocates for single-payer, nationalized health care have pointed out that the United States’ per capita *public spending* on health care would pay for *all per capita health spending* in nearly any other advanced industrial nation.¹⁰ Drugs, devices, hospital services, and the time of most physicians are markedly more expensive in the United States than in most of Europe.¹¹

A naïve defense of U.S. health costs might simply take the high prices as evidence that Americans prefer to allocate the per capita gross domestic product (GDP) that the United States produces, beyond that produced in similar countries, on health care. For example, in 2012, the United States’ per capita GDP was \$51,689; it was only \$41,923 in Germany and \$42,114 in Canada.¹² In 2011, per capita health expenditures in the three countries were

tonsillectomy, the hysterectomy, the frontal lobotomy, the radical mastectomy, arthroscopic knee surgery for arthritis, X-ray screening for lung cancer, proton pump inhibitors for breast cancer, to name just a few, have ultimately been shown to be unnecessary, ineffective, more dangerous than imagined, or sometimes more deadly than the diseases they were intended to treat.

Id.

7. DAVID A. SQUIRES, THE COMMONWEALTH FUND, EXPLAINING HIGH HEALTH CARE SPENDING IN THE UNITED STATES: AN INTERNATIONAL COMPARISON OF SUPPLY, UTILIZATION, PRICES, AND QUALITY 4–5 (2012), available at http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2012/May/1595_Squires_explaining_high_hlt_care_spending_intl_brief.pdf.

8. Maggie Fox, *What makes U.S. Health Care So Overpriced? It's Not What You Think*, NBC NEWS (Nov. 12, 2013, 11:44 AM), <http://www.nbcnews.com/health/health-care/what-makes-u-s-health-care-so-overpriced-its-not-f2D11582695> (quoting a study by Hamilton Moses of the Alerion Institute and Johns Hopkins University).

9. Ezra Klein, *Why an MRI cost \$1,080 in America and \$280 in France*, WASH. POST (Mar. 3, 2012, 12:08 PM), http://www.washingtonpost.com/blogs/wonkblog/post/why-an-mri-costs-1080-in-america-and-280-in-france/2011/08/25/gIQAVH2toR_blog.html.

10. Steffie Woolhandler & David U. Himmelstein, *Paying for National Health Insurance—And Not Getting It*, 21 HEALTH AFF. 88, 92–93 (2002).

11. Gerard F. Anderson, Uwe E. Reinhardt, Varduhi Petrosyan, *It's The Prices, Stupid: Why The United States Is So Different From Other Countries*, 22(3) HEALTH AFFAIRS 89, 91 (2003).

12. *Gross domestic product (expenditure approach)—Per head, US \$, current prices, current PPPs*, ORGANIZATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT, (May 25, 2014),

\$8,508, \$4,495, and \$4,522, respectively.¹³ It is not unimaginable that \$4,000 of that roughly \$10,000 gap would rationally be spent on the health sector. It is hard to enjoy much else if one's health is poor.

On the other hand, the typical patient in the United States is not obtaining demonstrably better outcomes in exchange for the extra spending. U.S. life expectancy is about the same as that prevailing in countries like Canada and Germany. Other aspects of quality of care (such as wait times for doctors) are not noticeably better in the United States either.¹⁴ So it is hard to excuse the higher U.S. expenditures as the cost of quality. Nor do they appear to reflect direct consumer choice, given that so much health spending is involuntary (no one chooses to get sick) and is channeled through third-party payers.

The *mediation* of most health care spending in the United States—by physicians (who stand between patients and treatment options), insurers (who stand between patients and doctors), and employers and government entities (who stand between patients and insurers)—leads to a fundamental divide on the *explanation* of higher U.S. costs. For mainstream American economists, the central problem is that government regulation and subsidies distort the outcomes that a “normal” market would provide.¹⁵ Victor Fuchs (an academic “sometimes called the dean of American health care economists,” according to New York Times economics journalist David Leonhardt) frequently evokes what he takes to be normal market goods as comparators for health care. “If there were third-party payments for personal computers, expenditures for PCs would surely be greater than at present. Even if consumers did not purchase more computers, many would be tempted to purchase top-of-the-line models,” Fuchs argues, in an article meant to explain why health care expenditures are inappropriately high.¹⁶ That leads to even more of what he deems distortions to “offset overutilization of health care” by imposing constraints like “fixed budgets for hospitals and physicians, quantitative limits on supplies of personnel and facilities, and alternative payment mechanisms such as capitation.”¹⁷ Conventional economists tend to derogate these tactics, which they see as troubling deviations from ideal-typical free markets. In their place, they

<http://stats.oecd.org/index.aspx?queryid=218>.

13. *OECD Health Data 2014—Frequently Requested Data*, ORGANIZATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT, <http://www.oecd.org/els/health-systems/health-data.htm> (last visited Nov. 26, 2014).

14. Karen Davis, Kristof Stremikis, David Squires, & Cathy Schoen, *Mirror, Mirror on the Wall, 2014 Update: How the U.S. Health Care System Compares Internationally*, THE COMMONWEALTH FUND (June 16, 2014), <http://www.commonwealthfund.org/publications/fund-reports/2014/jun/mirror-mirror>.

15. The scare quotes around the word “normal” are meant to denote the diversity of arrangements commonly called “markets.” There are standard markets for given commodities and services, but it is very difficult to identify underlying unities for all such markets.

16. Victor Fuchs, *Health Care Is Different—That's Why Expenditures Matter*, 303 JAMA 1859, 1859 (2010).

17. *Id.*

propose various mechanisms (such as vouchers or health savings accounts) designed to bring American health care closer to what they deem a true market.

Far less represented in American health policy debates are *comparative* health law scholars who locate American health expenditure exceptionalism precisely in its health care system's more market-oriented—or, at least, profit-oriented—nature. Other industrialized nations' health care systems tend to feature deeper government involvement in the provision of care, the regulation of insurance, and guarantees of access to care. Direct price controls are far more common. In the United States, the profit motive has a much larger role in the provision of care. Many changes in the delivery and organization of health care services over the past two decades have come about in part (and sometimes, primarily) to boost compensation to top executives and shareholders of insurers, and well-placed providers.

It is this fundamental clash over values—over whether the profit motive and markets should play a larger or smaller role in U.S. health care—that rhetoric of “cost containment” tries to smooth over. Settling this key question will, in turn, depend on fine-grained analyses of diverse actors in the U.S. health care system. The next section frames a research agenda for such analyses, highlighting the importance of *raising* returns to undercompensated providers of care, even if there is a fair amount of waste by other providers.

III

TOWARD A MORE TEXTURED ANALYSIS OF HEALTH CARE EXPENSES

Aggregate health spending figures are problematic. Such figures roll together expenditures on items that have been overpriced (like the drug Zaltrap, which was initially priced twice as high as Avastin with little to no discernible advantage over the older drug)¹⁸ with other interventions that are underfunded (like health information technology, personalized medicine, home health aides, care coordination, public health measures, and preventive care).¹⁹ They combine extraordinary profits and executive incomes together with the pittances paid to vital workers in the sector. To achieve a more textured and accurate view, *where* health care funds are being spent must be considered as well as who is benefiting from those expenditures and what the distribution of income is across health subsectors.

Given careful consideration of the full range of real health care costs (and their benefits), it is by no means clear that the United States is “spending too

18. See Paul Goldberg, *MSKCC Bars Zaltrap From Formulary, Triggering Debate Over Drug Pricing*, 38 THE CANCER LETTER 1, 1–2 (2012); Matthew Herper, *Sanofi's CEO On The New York Times' Criticism of Drug Prices And Surviving The Patent Cliff*, FORBES (Oct. 26, 2012, 10:14 AM), <http://www.forbes.com/sites/matthewherper/2012/10/26/sanofis-ceo-on-the-new-york-times-criticism-of-drug-prices-and-surviving-the-patent-cliff/>; Andrew Pollack, *Sanofi Halves Price of Cancer Drug Zaltrap After Sloan-Kettering Rejection*, N.Y. TIMES, Nov. 9, 2012, at B3.

19. For an analysis of the undervaluation of home health care, see ROBERT KUTTNER, OBAMA'S CHALLENGE 146–53 (2012) (calling for professionalization and pay increases in the sector).

much” on all forms of health care. As Enthoven and Kronick noted in 1989, the American health care system is a “paradox of excess and deprivation,” far more in need of *redistribution* of expenditures than overall cuts.²⁰

Hospitals exemplify the problem. They occupy an odd place in health reform literature. For many cost-cutters, they are public enemy number one: sites of unforgivable waste and unwise cross-subsidization.²¹ And yet policymakers are also counting on them to deliver “health system transformation,” via initiatives ranging from accountable care organizations to patient-centered medical homes. These two strands of advocacy could combine into a seamless garment, if hectoring over high costs inevitably spurred hustle to improve services. Unfortunately, hospitals may need to invest much more in information technology (IT) and innovative care delivery *now* in order to save money in the future. Cutting spending on, say, health IT, over the next few years may make it impossible to carry out the type of comparative effectiveness research and quality improvement strategies that would avoid unnecessary expense in the future.

The real challenge for health policy is to better match the economic returns to health interventions to the benefit they provide. At present, for many interventions, it is hard to determine whether they reliably increase length and quality of life. In advertising, this has been a familiar problem: in the pre-Internet age, it was often said that “half of ad spending is wasted; we just don’t know which half.” With the rise of Google, Facebook, and sophisticated ad networks, that is less and less true: databases record click-through rates and track customer engagement with ever more specificity. But unlike Silicon Valley’s hypertechnologized world of online ad delivery, health care IT is mired in interoperability problems.²² Moreover, even if these IT problems were overcome tomorrow, the world of health care outcomes is far more difficult to measure than the usual tasks of the Internet economy. Google can quickly determine whether, say, a blue background for ads leads to more clicks than a grey background. But how easily can a given hospital, or many hospitals, combine data to assess the effect of changing practice patterns? Finally, the relative value of various health care outcomes can be contestable, as controversy over Oregon’s famous Medicaid rationing experiment showed.

There is some hope that a combination of health information exchange, interoperability advances, and more widespread adoption of learning health

20. Alain Enthoven & Richard Kronick, *A Consumer-Choice Health Plan for the 1990s*, 320 NEW ENG. J. MED. 29, 29 (1989).

21. On the role of cross-subsidization, see *see* Frank Pasquale, *Ending the Specialty Hospital Wars*, in FRAGMENTATION IN AMERICAN HEALTH CARE 236 (Einer Elhauge, ed., 2010).

22. Susan D. Hall, *Poor interoperability a significant barrier for ACOs*, FIERCEHEALTHIT, <http://www.fiercehealthit.com/story/poor-interoperability-significant-barrier-acos/2014-09-25> (last visited Nov. 26, 2014); Susan D. Hall, *ACOs' Health IT Capabilities Remain Rudimentary*, FIERCEHEALTHIT, (Aug. 13, 2014), <http://www.fiercehealthit.com/story/acos-health-it-capabilities-remain-rudimentary/2014-08-13>.

care system models will lead to the types of personalized medicine that can maintain or promote quality while cutting costs. The HITECH Act of 2009 has advanced adoption of health information technology, and the Patient Protection and Affordable Care Act (PPACA) prescribed accountable care organizations (among many other programs) to encourage data-driven evaluation of health care.²³ Nevertheless, there is still a great distance between the rhetoric of books like *The End of Illness* and the more mundane realities of health information sharing.²⁴ Indeed, dozens of humbler interventions designed merely to stop errors remain inexcusably underutilized in most hospitals. If there is not strong demand for existing technologies of harm reduction, it is hard to see insurers driving far more ambitious innovation.

Indeed, some safety net hospitals seem desperate for cash infusions to maintain basic care. In 2008, a report on the Grady Memorial Hospital in Atlanta revealed that:

Every week or so, a vehicle simply gives out while in transit, and [the supervisor] prays that the patient will not die before she can orchestrate a rescue. . . . The orthopedic department has a waiting list for elective procedures that one doctor quantified as “infinity.” Its doctors intermittently instruct other departments to not send them patients.²⁵

The Affordable Care Act (ACA) was widely hailed as financial salvation for such hospitals since it was supposed to provide Medicaid coverage for a high proportion of the poor uninsured. But the Supreme Court insisted that states had the right not to implement that part of the ACA and to stick with the old “categorical eligibility” design of Medicaid.²⁶ Even worse, in part to satisfy the technocratic cost-cutters at the Congressional Budget Office (CBO) and in the Obama Administration, the ACA cut Disproportionate Share Hospital (DSH) payments to hospitals like Grady on the assumption that the revenues from the population covered by the Medicaid expansion would make up the lost payments.²⁷ So now Grady and similarly situated hospitals must make do with declining DSH payments and less than the promised Medicaid expansion.

Even in states that are expanding Medicaid, many hospitals are at the

23. Frank Pasquale, *Grand Bargains for Big Data: The Emerging Law of Health Information*, 72 Maryland Law Review 682, 728 (2013).

24. DAVID B. AGUS, *THE END OF ILLNESS* 3 (2011) (“The end of illness is closer than you think.”).

25. Shaila Dewan & Kevin Sack, *A Safety-Net Hospital Falls Into Financial Crisis*, N.Y. TIMES (Jan. 8, 2008), <http://www.nytimes.com/2008/01/08/us/08grady.html>.

26. Nat’l Fed’n of Indep. Bus. v. Sebelius, 132 S.Ct. 2566, 2601–07 (2012).

27. The CBO deserves special censure for its role as an ideological “enforcer” of cost-cutting, systematically skewing legislators against government action, and under-recognizing the value of relieving suffering, offering security, and enriching the health and education of citizens. For the CBO, the working poor, the uninsured, and students are systematically undervalued. See Will Bunch, *America’s Cruel Political Math—Where the Working Poor Equal Less Than Zero*, HUFFINGTON POST (Feb. 25, 2014, 11:59 AM), http://www.huffingtonpost.com/will-bunch/minimum-wage-working-poor_b_4844606.html; Frank Pasquale, *Politicized Prognostication at CBO*, BALKINIZATION (July 28, 2009), <http://balkin.blogspot.com/2009/07/politicized-prognostication-at-cbo.html>.

breaking point. As one New York hospital executive observed, community hospitals have “cut costs on staffing and support services,” and stopped “spending money to keep . . . physical plant[] and equipment up to date,” to the extent that “[t]he condition of the physical plants of many New York City hospitals is staggering.”²⁸ When local hospitals close, the resulting unemployment devastates local economies and sometimes leaves the critically ill with very long ambulance rides to emergency care.²⁹ A new online game dramatizes the situation, “[h]aving players experience the anxiety of seeing a victim with no hospitals nearby” in order to give “them an intuitive and memorable understanding of how the lack of emergency care affects neighborhoods.”³⁰

For now, the worst deprivation resulting from health care cost-cutting afflicts the poorest parts of the United States the most. But the reduction in hospital facilities and other resources, although “efficient” in normal times, may prove disastrous if there is an epidemic. For example, one national-preparedness plan for pandemic flu estimated that, in a worst-case scenario, the United States would be short over 600,000 ventilators.³¹ “To some experts, the ventilator shortage is the most glaring example of the country’s lack of readiness for a pandemic,” one journalist noted.³² The lack of “surge capacity” throughout the health care industry is a major infrastructural shortcoming, likely to cause tremendous, avoidable suffering if a pandemic emerges.³³

In the hoped-for world of the health care cost-cutter, doctors will scale back their own demands for reimbursement to match patients’ ability to pay, if only policymakers would bite the bullet and reduce patients’ effective purchasing power.³⁴ Unfortunately, this “just-so” story has little foundation in actual studies of the redistributive effects of ending subsidies. It is hard to know whether the reduced purchasing power of working people (or their employers) would actually (motivate insurers to) force physicians and pharmaceutical firms to accept lower prices.³⁵ If offered lower prices from ordinary working people,

28. Mark Levine, *St. Vincent’s is the Lehman Brothers of Hospitals*, N.Y. MAG. Oct. 17, 2010, <http://nymag.com/news/features/68991/> (quoting a hospital executive).

29. See Jon Nichol et al., *The Relationship Between Distance to Hospital and Patient Mortality in Emergencies: An Observational Study*, 24 EMERGENCY MED. J. 665 (2007).

30. Sisi Wei et al., *HeartSaver: Experimenting with News Games to Tell a Story*, PROPUBLICA (Apr. 23, 2013, 10:51 AM), <http://www.propublica.org/nerds/item/heartsaver-an-experiment-in-using-news-games-to-tell-a-story>.

31. Don McNeil, *Hospitals Short on Ventilators if Bird Flu Hits*, N.Y. TIMES (Mar. 12, 2006), <http://www.nytimes.com/2006/03/12/national/12vent.html?adxnnl=1&adxnnlx=1142295570-FVGWQZzHnI8Qy0EO3+gKUA&pagewanted=print>.

32. *Id.*

33. Vickie J. Williams, *Fluconomics: Preserving Our Hospital Infrastructure During and After a Pandemic*, 7 YALE J. HEALTH POL’Y L. & ETHICS 99, 132 (2007).

34. Joseph Bankman et al., *Reforming the Tax Preference for Employer Health Insurance*, in TAX POLICY AND THE ECONOMY 43, 43–44 (2012) (alleging negative effects of ESI).

35. White, *infra* note 69, at 42.

doctors may simply switch their efforts to high-end, cash-only boutique, or concierge, practices.³⁶ Magazines like *Medical Economics* constantly suggest ways for physicians to maximize cash flow.³⁷ Indeed, both trade journalists and economists have recognized the pervasiveness of physicians' income maintenance.³⁸ Like a balloon that, when squeezed in one part, pops out in another, physician incomes have a way of maintaining their overall volume.³⁹

Macrolevel analyses of health expenditures also need to contextualize physician compensation. Given the rapid rise of both incomes and wealth among the top 1% (and especially top 0.1%) of taxpayers, it should not be surprising when even the highest-paid physicians fight to maintain their relative position. A typical American orthopedist may make twice or three times what a Belgian orthopedist earns but is paid a trivial sum compared to many rentiers and managers with better working conditions, less educational investment, and less contribution to social welfare. Moreover, given the political influence of money, the outsized salaries of these financiers and CEOs do not merely mean that they enjoy more consumer goods. Rather, to the extent health care providers have less money to invest in campaigns and lobbying, they consign themselves to losing out in future political battles over the relative allocation of health care dollars among managers, investors, and providers. In an era of unconstrained campaign spending, investing in politicians is a critical business strategy.⁴⁰

36. See Peter A. Clark et al., *Concierge Medicine: Medical, Legal and Ethical Perspectives*, 7 INTERNET J.L. HEALTHCARE & ETHICS 1, 1 (2010), available at <http://ispub.com/IJLHE/7/1/7969>; Frank Pasquale, *Access to Medicine in an Era of Fractal Inequality*, 19 ANNALS OF HEALTH L. 269, 282 (2010); Frank Pasquale, *Three Faces of Retainer Care*, 7 YALE J. HEALTH POL'Y, L. & ETHICS 39, 41 (2007).

37. See Frank Cohen, *Lines of Credit: A Tool to Boost Reserves and Sustain Cash Flow at Your Practice*, MED. ECON. (Apr. 24, 2014), <http://medicaleconomics.modernmedicine.com/medical-economics/content/tags/cash-flow/lines-credit-tool-boost-reserves-and-sustain-cash-flow-your>; Marisa Manley, *Using Your Office Lease to Manage Cash Flow*, MED. ECON. (May 23, 2014), <http://medicaleconomics.modernmedicine.com/medical-economics/content/tags/cash-flow/using-your-office-lease-manage-cash-flow>; Stanley M. Smith II & Matthew Frooman, *Selling Your Practice: Planning Is Crucial-How to Maximize After-Tax Cash Flow*, MED. ECON. (Jan. 25, 2012), <http://medicaleconomics.modernmedicine.com/medical-economics/news/modernmedicine/modern-medicine-feature-articles/selling-your-practice-plannin?page=full>; Christina Van Vort, *How Physicians Can Improve Cash Flow with Accounts Receivable Financing*, MED. ECON. (Mar. 24, 2014), <http://medicaleconomics.modernmedicine.com/medical-economics/content/tags/accounts-receivable/how-physicians-can-improve-cash-flow-accounts-rec>.

38. See, e.g., Lori Melichar, *The effect of reimbursement on medical decision making: Do physicians alter treatment in response to a managed care incentive?*, 28 J. HEALTH ECON. 902, 906 (2009) (finding that physicians "with capitated care contracts make treatment decisions that are not inconsistent with profit-maximization"); Karen Nash, *Urologists Struggle to Make up for Lost Reimbursement*, UROLOGY TIMES, June 2005, at 38 (discussing the ways urologists attempted to maintain their incomes in response to Medicaid reimbursement cuts).

39. The phenomenon may express itself either as a maintenance of overall income, or income per patient or per hour. See, e.g., Jack Hadley & Jean M. Mitchell, *Effects of HMO Market Penetration on Physicians' Work Effort and Satisfaction*, 16 HEALTH AFF. 99, 109 (1997).

40. See generally JAMES K. GALBRAITH, *THE PREDATOR STATE: HOW CONSERVATIVES ABANDONED THE FREE MARKET AND WHY LIBERALS SHOULD TOO* (2008); G. RICHARD SHELL,

The financing of medical education (and even of medical residencies) also helps explain why American physicians demand more pay than those in other nations with similar levels of professionalism and health outcomes. Medical school in the United States leaves many of its doctors far deeper in debt at the beginning their careers than comparable professionals elsewhere. For example, if a primary care physician is using forty percent of her income to pay student debt and interest on a mortgage, we may wonder whether the differential between what she makes and the lower pay she would likely earn in another advanced country is really a problem of a wasteful health care sector, or, at least in part, a problem of U.S. patterns of financing education and housing. Leaving physicians hundreds of thousands of dollars in debt at the beginning of their careers is penny-wise and pound-foolish: it saves funds now, but pressures doctors to maximize incomes as rapidly as possible to pay back loans.

Finally, close consideration of the potentially self-defeating role of private insurers as gatekeeping cost-cutters is crucial. U.S. doctors spend four times as much money on interactions with insurers as Canadian doctors.⁴¹ Multispecialty group practices “spend 13.9% of revenues for billing- and insurance-related overhead.”⁴² Private health insurers were supposed to control costs, and did play some role in doing so in the 1990s, but they have lately come to be seen as cost centers themselves. The ACA now imposes a medical loss ratio (MLR) rule to limit most insurers’ administrative take to fifteen to twenty percent of premiums paid.⁴³ But insurers may respond by increasing premiums to expand the baseline of funds from which they can draw that fifteen or twenty percent. If that happens, the MLR may end up yet another futile technocratic cog in our health system’s Rube Goldberg machine of cost containment.⁴⁴

IV

REVALUING VS. DEVALUING HEALTH CARE

Shimon Peres once observed that, when a problem cannot be solved, it is no longer a problem—it is a fact.⁴⁵ For many Americans, mortgage payments or

MAKE THE RULES OR YOUR RIVALS WILL (2004).

41. Dante Morra et al., *US Physician Practices Versus Canadians: Spending Nearly Four Times As Much Money Interacting With Payers*, 30 HEALTH AFF. 1443, 1443 (2011). For concrete examples of the inefficiencies involved, see Steven P. Ringel, *Practicing Medicine Versus Pushing Paper*, 30 HEALTH AFF. 1200, 1200–03 (2011).

42. Ray E. Drasga & Lawrence H. Einhorn, *Why Oncologists Should Support Single Payer National Health Insurance*, J. ONCOLOGY PRAC. (2013), available at <http://org.salsalabs.com/o/307/images/Drasga%20Einhorn%20authors%20proof-edited%20%281%29.pdf>.

43. *Medical Loss Ratio*, CENTERS FOR MEDICARE AND MEDICAID SERVICES, <http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Medical-Loss-Ratio.html> (last visited Dec. 2, 2014).

44. See Mike Konczal, *What Kind of Problem is the ACA Rollout for Liberalism?*, NEXT NEW DEAL (Oct. 23, 2013), <http://www.nextnewdeal.net/rortybomb/what-kind-problem-aca-rollout-liberalism>.

45. *Sharon’s Victory*, WALL ST. J., Feb. 7, 2001, at A26 (“If a problem has no solution, it may not

high cable bills or bank fees are simply assumed as an inevitable part of contemporary civilization, whereas health costs are politicized, manipulable, and thus more objectionable. For example, in *Deadly Spin*, ex-insurance executive Wendell Potter describes a struggling middle class family's financial travails as follows:

[The Brennan family is] thinking now that they would be better off without insurance. They pay more than \$7,000 a year in premiums and still have almost \$11,000 in combined deductibles—and they have to pay the full cost of prescription drugs because medications are not covered under either of their policies. “Because of the high deductibles, we still wind up paying for everything out of pocket,” said Katie. “We now avoid going to the doctor. . . . The cost of our premiums and out-of-pocket costs exceed our monthly mortgage payments.”⁴⁶

Two questions immediately arise here. First, *why* are costs so high? That should be the first question of health care cost-cutters, not generalizations about whether the service as a whole costs too much. Second, what are the proper comparators for health care costs? The Brennans complain that the costs exceed a mortgage payment—but to what extent is the real estate sector itself inflated by government action?⁴⁷ Like medical bills, housing prices are artifacts of socialized financing mechanisms. Housing also has enormous built-in tax advantage for the tens of millions of American households that own homes and are paying a mortgage: the interest payments on the mortgage are tax-deductible. All these subsidies are submerged in ordinary talk about real estate, which presumes that rents or mortgage payments *should* be a family's largest expense.⁴⁸

This is not to say that the Brennans should not be complaining about their plight: far from it. My position is simply that all wasted spending is relative. In the aggregate, useless spending on American health care may well surpass the over \$600 billion estimated by Wallace Turbeville to be excessively allocated to the finance sector each year.⁴⁹ For example, the Institute of Medicine issued a report in the fall of 2012 claiming that \$750 billion of the \$2.6 trillion the United States spent on health care was unnecessary.⁵⁰ Nevertheless, even accepting such

be a problem, but a fact, not to be solved, but to be coped with over time.”).

46. WENDELL POTTER, *DEADLY SPIN* 102 (2010).

47. See Stephanie M. Stern, *Residential Protectionism and the Legal Mythology of Home*, 107 MICH. L. REV. 1093, 1103–04 (2009) (describing subsidies to housing market and financial, insurance, and real estate (FIRE) sector).

48. See generally SUZANNE METTLER, *THE SUBMERGED STATE: HOW INVISIBLE GOVERNMENT POLICIES UNDERMINE AMERICAN DEMOCRACY* (2011) (discussing the role of hidden subsidies and tax discounts in redistributive policies).

49. Wallace C. Turbeville, *A New Perspective on the Costs and Benefits of Financial Regulation: Inefficiency of Capital Intermediation in a Deregulated System*, 72 MD. L. REV. 1173, 1179 (2013); see also John Quiggin, *Wall Street Isn't Worth It*, JACOBIN (2013), available at <https://www.jacobinmag.com/2013/11/wall-street-isnt-worth-it/>.

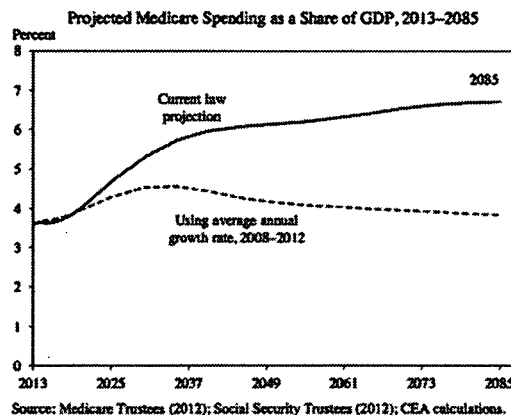
50. See Sarah Kliff, *We spend \$750 billion on unnecessary health care. Two charts explain why*, WASH. POST (Sept. 7, 2012, 11:07 AM), <http://www.washingtonpost.com/blogs/wonkblog/wp/2012/09/07/we-spend-750-billion-on-unnecessary-health-care-two-charts-explain-why/>; *The Cost of Health Care: How Much is Waste?*, INSTITUTE OF MEDICINE, <http://resources.iom.edu/>

massively aggregative estimates at face value does not necessarily indicate overspending in the sector as a whole, but rather could simply indicate misallocation therein.

Some lamentations about rising health care costs indulge in “bubble-ology,” an ersatz science of overvaluation. Look hard enough in the finance press, and nearly everything is (or has been) called a bubble: stocks, bonds, housing, education, and, of course, health care.⁵¹ Fusing description and judgment, the bubble-ologist compares the price of the alleged bubble to something he finds much more valuable, and declares the bubble far less valuable. There are dire warnings that some eventuality (changed government policy, wiser consumers, sudden inflation or deflation) will eventually prick the bubble, leaving rubes scrambling for a safer investment (often one shilled by the very would-be diagnoser of the bubble).

Closely related to bubble-ology is the “frightening projections” school of health care–cost alarmism. Some economists project health care costs increasing at a rate so fast that they take up the entirety of GDP within several decades, however impossible that may be as an empirical matter. Critical policy decisions about Medicare over the past few years, for instance, were built on assumptions about medical inflation that now appear unrealistic:

Figure 1



The ability of *any* social scientist, no matter how brilliant, to make accurate predictions about expenditure patterns in 2025, let alone 2085, is questionable. Both the “[c]urrent law projection” in the chart above and the course correction exhibit ill-advised confidence in technocratic extrapolation.⁵² Their outer limits

widgets/vsrt/healthcare-waste.html (last visited Mar. 29, 2014).

51. See Neil Irwin, *Another billionaire is predicting doom. Ignore him.*, WASH. POST (Oct. 23, 2013, 1:36 PM), <http://www.washingtonpost.com/blogs/wonkblog/wp/2013/10/23/another-billionaire-is-predicting-doom-ignore-him/> (critiquing alleged “bubbles” in various sectors of the economy).

52. CHARLES TAYLOR, *Interpretation and the Sciences of Man*, in PHILOSOPHY AND THE HUMAN SCIENCES 55 (1985) (“exact prediction [in social science] is radically impossible, for three reasons of ascending order of fundamentalness.”)

are about as scientific as singularitarian predictions of mass immortality by 2100.

Even ostensibly sober analysts have tended to “sound the alarm” on health care costs with some dubious predictions. For example, the Intermediate Projections from Annual Reports of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds have frequently foretold doom for the Medicare Part A Trust Fund.⁵³ In 1970, the fund was supposed to be depleted by 1972; doom was just six years away in 1993; and in 1998, calamity loomed in 2008.⁵⁴ The CBO has also repeatedly overestimated the budgetary threat posed by rising government spending on health care.⁵⁵ Sometimes, these overestimates border on the ghoulish. For example, the CBO has embraced the concept of “survivors’ costs” in some scoring of legislative proposals.⁵⁶ Such analysis essentially values the early death of a person denied coverage for care as a benefit (or, at least, avoided costs) to the public fisc. Beyond its defective moral foundations, such cost alarmism can prove self-undermining by pushing more health care provision into the private sector, where insurers have repeatedly proven *less* able to control costs than their purely public-sector counterparts.⁵⁷

The wisest commentators on health care costs concede that “[t]here is, of course, no ‘right’ amount for a society to spend on health care.”⁵⁸ Others nevertheless focus on disparities among nations with similar lifespans as the United States.⁵⁹ Clark C. Havighurst has argued that “it is facially troublesome that health care spending represents one-seventh of GDP in the United States (even without providing fully for a huge segment of the population) while

53. Kaiser Family Foundation, *Rhyme or Reason?: Solvency Projections of the Medicare Part A Trust Fund, 1970–2010* (2010) (health resource data set compiling intermediate projections from 1970–2010 Annual Reports of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds) (on file with author).

54. PATRICIA A. DAVIS, CONG. RESEARCH SERVICE, *MEDICARE: INSOLVENCY PROJECTIONS 4* (2013), available at <http://fas.org/sgp/crs/misc/RS20946.pdf>

55. See Pasquale, *Politicized Prognostication*, *supra* note 27 (discussing examples of the CBO overestimating health care expenses and the unreliability of CBO estimates).

56. Tim Westmoreland, *Standard Errors: How Budget Rules Distort Lawmaking*, 95 GEO. L.J. 1555, 1597 (2007) (quoting CONG. BUDGET OFFICE, *ISSUES IN DESIGNING A PRESCRIPTION DRUG BENEFIT FOR MEDICARE* 33 (2002), available at <http://cbo.gov/sites/default/files/cbofiles/ftpdocs/39xx/doc3960/10-30-prescriptiondrug.pdf> (In describing why its model included costs but no savings from new access to pharmaceuticals, the CBO said, *inter alia*, “[T]o the extent that a drug benefit helps people live longer, they may consume more health care over their remaining lifetime than they would have without the benefit.” In other words, it is still cheaper for Medicare beneficiaries to die.)).

57. See Frank Pasquale, *Health Care Dilemma: Cost Control vs. Profit Maximization*, CONCURRING OPINIONS (Feb. 10, 2008), http://www.concurringopinions.com/archives/2008/02/health_care_cos.html.

58. Timothy Stoltzfus Jost, *Policing Cost Containment: The Medicare Peer Review Organization Program*, 14 U. PUGET SOUND L. REV. 483, 484 (1991).

59. See *id.* (comparing the percent of U.S. GDP spent on health care to that of Canada, Germany, Japan, and the United Kingdom).

accounting for only a ninth of GDP or less in all other developed nations.”⁶⁰ But the “percentage of overall GDP” alarm has been sounded many times in the past. For example, in 1980, an economist lamented that “[w]e spend about 9% of our gross national product on personal health care.”⁶¹ He would probably have predicted disaster for the United States if he knew that the spending level was on its way up to its current status of about eighteen percent of GDP. But however badly off the United States may be at present, it is relatively clear that the crisis was primarily triggered by the financial, not the health, sector. Growth in health employment over the past decade has been one of the few bright spots in an otherwise gloomy macroeconomic picture.⁶² And it would be the height of insensitivity to tell millions of unpaid family caregivers that they should be denied some care assistance simply because an abstraction like “health expenditures” has grown too large.

Societies’ needs and wants change over time. There is little reason to benchmark proper health care spending levels to some arbitrary year in the past, or even some arbitrary global benchmark—particularly when U.S. GDP is higher than that prevailing in so many of the cost-cutters’ favored comparators. Future increases in health expenditures, and even increases in the share of national income they consume, do not automatically undermine the typical household’s well-being—and may well enhance it.⁶³ With a sufficiently long view of economic transitions, radical changes in societal allocation of resources appear more natural than ossified stability. If the U.S. workforce in agriculture could decline precipitously in a matter of decades, why should its labor in health care not rise by, say, twenty or thirty percent over the course of the twenty-first century? And why would a corresponding capture of that share of GDP for such workers be so problematic if it were accompanied by a commensurately diminishing share for rentiers, landlords, energy barons, and communication magnates?

Indeed, resisting such a development may prove macroeconomically self-defeating. To give one striking example: a Rand study recently concluded that the “total opportunity costs of informal elder-care amount to \$522 billion annually.”⁶⁴ The study suggests that a combination of unskilled and skilled

60. Clark C. Havighurst, *How the Health Care Revolution Fell Short*, 65 LAW & CONTEMP. PROBS. 55, 81 (2002). He also notes that “[s]everal whole percentage points of the nation’s gross domestic product (‘GDP’) are thus diverted wastefully to health care from other uses.” *Id.* at 79.

61. Ralph L. Andreano, *Does America Spend Too Much on Health Care?*, 56 BULL. N.Y. ACAD. MED. 19, 19 (1980), available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1808285/pdf/bullnyacadmed00110-0023.pdf>.

62. See Catherine A. Wood, *Employment in Health Care: A Crutch for the Ailing Economy During the 2007-09 Recession*, MONTHLY LAB. REV., Apr. 2011, at 13.

63. DAVID M. CUTLER, YOUR MONEY OR YOUR LIFE: STRONG MEDICINE FOR AMERICA’S HEALTH CARE SYSTEM 74 (2005) (projecting that the typical household is expected to earn \$75,000 annually by mid-century and that, even if 25% of that annual income were consumed by insurance and direct medical expenses, the household would still be better off).

64. A.V. Chari, John Engberg, Kristin Ray, Ateev Mehrotra, *The Opportunity Costs of Informal*

replacement care could result in net economic gains for the United States. Such replacement care would increase “health care costs,” but could lead to net economic gains overall, particularly for women (who disproportionately shoulder the burden of unpaid caregiving). A policy debate relentlessly focused on reducing health expenditures may promote self-defeating savings strategies, as obvious, immediate savings are eventually overwhelmed by later, hidden costs. How we choose to measure benefits and costs can spotlight some results and submerge others.⁶⁵ Even accounting is political.

The dynamic, long-term effects of short-term cost-cutting measures like consolidation are also understudied.⁶⁶ A wave of hospital mergers in the 1990s helped increase concentration in the industry.⁶⁷ Merging hospitals probably saved administrative costs and achieved other efficiencies in the short run.⁶⁸ But over time, the biggest hospitals and hospital chains have also leveraged their size into bargaining power vis-à-vis insurers, employers, and patients.⁶⁹ Joseph White has described in grim detail the arms race for size among hospitals and insurers.⁷⁰ It is much easier for large insurers to pass along cost increases to employers than to bargain hard with must-have providers. Massive hospital systems have unleashed untold ingenuity in figuring out how to bill payers more aggressively for their services.⁷¹ Some have earned their investors princely sums.⁷² These outsized returns might be more properly considered *finance*

Elder-Care in the United States: New Estimates from the American Time Use Survey, HEALTH SERVICES RESEARCH, DOI: 10.1111/1475-6773.12238 (2014), available at http://www.rand.org/pubs/external_publications/EP66196.html (copy on file with author and shared with journal).

65. SUZANNE METTLER, *THE SUBMERGED STATE: HOW INVISIBLE GOVERNMENT POLICIES UNDERMINE AMERICAN DEMOCRACY* (2011) (arguing that many upper income individuals do not realize the extent to which their lifestyles are subsidized by “upside down subsidies,” like the home mortgage interest deduction, that tend to deliver benefits disproportionately to the wealthiest (who tend to have the largest mortgages)).

66. See generally FINAL REPORT, NEW JERSEY COMMISSION ON RATIONALIZING HEALTH CARE RESOURCES (2008), available at http://nj.gov/health/rhc/finalreport/documents/entire_finalreport.pdf.

67. WILLIAM B. VOGT & ROBERT TOWN, *THE SYNTHESIS PROJECT, HOW HAS HOSPITAL CONSOLIDATION AFFECTED THE PRICE AND QUALITY OF HEALTHCARE 1* (2006), available at <http://www.rwjf.org/en/research-publications/find-rwjf-research/2006/02/how-has-hospital-consolidation-affected-the-price-and-quality-of.html>.

68. For an account of varying strategies of efficiency improvement in hospital reorganization, see Frank Pasquale, *Ending the Specialty Hospital Wars*, in *FRAGMENTATION IN AMERICAN HEALTH CARE* (Einer Elhauge, ed., 2010).

69. Joseph White, *Markets and Medical Care: The United States, 1993–2005*, 85 *MILBANK Q.* 395, 435 (2007).

70. *Id.* at 419.

71. Julie Creswell & Reed Abelson, *Giant Hospital Chain Creates a Windfall for Private Equity*, *N.Y. TIMES* (Aug. 14, 2012), <http://www.nytimes.com/2012/08/15/business/hca-giant-hospital-chain-creates-a-windfall-for-private-equity.html>. Bain Capital and two other private equity firms bought HCA in 2006, and tripled the value of their holdings in six years. *Id.* Again, the accounting question arises: to what extent are HCA’s extraordinary profits health care costs, and to what extent are they rents to finance?

72. See, e.g., *id.*

rather than *health care* costs.⁷³

A. Questioning Crowd Out

All too often, an undifferentiated category of “health care” is assumed to crowd out other spending that is assumed to be worthier, like education or infrastructure. For example, health economist Victor Fuchs observes that “Americans spend more than 17 percent of GDP on health care; other high income industrial democracies spend only about 11 percent.” Since the “6 percent difference in our \$17 trillion economy amounts to \$1 trillion,” he reasons that, if the United States had a health care system more like that prevailing in other high income industrial democracies, it could “increase expenditures on highways, bridges, tunnels, and other infrastructure by 50 percent,” (a cost of \$100 billion), and have \$900 billion to spend on things like higher teacher salaries, renewable energy, and apprenticeship programs.⁷⁴ But Fuchs fails to identify the *transmission mechanism* between a health care cost-cut and increased spending on other, more worthy parts of the economy. This is not an isolated aporia. Health policy wonks frequently insist that Medicaid, as an expanding share of state budgets, has been eating into education, infrastructure, and other vital budgets. Rarely, if ever, is it acknowledged that any putative Medicaid savings imposed by, say, aggressively managed care, nonexpansion, or flat budget constraints, may simply be given back as tax cuts that are largely lagniappe for the top 10% (and especially top 1% and 0.1%) of families.⁷⁵ The median family may enjoy an extra pizza a week as well, or

73. As scholars like Greta Krippner have observed, the definition of financial returns has long been contested in the relevant economic, sociological, and historical literatures. Greta Krippner, *The financialization of the American economy*, SOCIO - ECONOMIC REVIEW, May 2005 (describing at least three definitions of financialization).

74. Victor R. Fuchs, *How to Shave \$1 Trillion Out of Health Care*, N.Y. TIMES, Mar. 14, 2014, at http://economix.blogs.nytimes.com/2014/03/14/how-to-shave-1-trillion-out-of-health-care/?_r=0.

75. For just one of many examples, see David Akadjian, *How Ohio Pulled \$4 Billion+ from Communities and Redistributed It Upwards*, DAILY KOS (Feb. 26, 2014, 5:36 AM), <http://www.dailykos.com/story/2014/02/26/1275645/-How-Ohio-Pulled-4-Billion-from-Communities-and-Redistributed-It-Upwards#>.

Figure 2

| 2012 income group | Lowest 20% | Second 20% | Middle 20% | Fourth 20% | Next 15% | Next 4% | Top 1% |
|--|--------------------|-------------------|-------------------|-------------------|--------------------|---------------------|-------------------|
| Income range | Less than \$18,000 | \$18,000-\$33,000 | \$33,000-\$51,000 | \$51,000-\$78,000 | \$78,000-\$143,000 | \$143,000-\$335,000 | \$335,000 or more |
| Average income in group | \$11,000 | \$25,000 | \$42,000 | \$63,000 | \$100,000 | \$203,000 | \$897,000 |
| Tax change as percent of income | 0.1% | -0.0% | -0.0% | -0.1% | -0.2% | -0.5% | -0.7% |
| Average tax change | \$12 | -\$5 | -\$9 | -\$36 | -\$176 | -\$983 | -\$6,083 |

Source: Institute on Taxation and Economic Policy, August 2013. Covers total 2012 income and includes Ohio residents only. Figures are rounded. See footnote 19 for further description.

whatever 1% or so of their income works out to, but that may be cold comfort if one of them finds herself consigned to a hollowed-out tier of a health care system highly stratified by cost-cutting.

For many of the health care cost-cutters, it is simply obvious that any money saved on health care would go to more socially valuable ends. Employer-sponsored insurance is one example: cost-cutters simply assume that most of the money saved would go to workers to spend on what they will. Rarely, if ever, is it acknowledged that, in the current climate of mass un- and underemployment, employers themselves are likely to keep the money. The average employee has little to no bargaining power.⁷⁶

Health care cost-cutters may claim that the firms' residual claimants to returns on equity deserve ever-larger shares of revenues relative to the providers and insurers the firms directly and indirectly pay for health care. So what is wrong with piling more funds into corporate cash piles? Consider the *distribution* of financial assets, like shares in firms, in U.S. society. As of 2010, about 85% of financial wealth was held by only 10% of Americans; the top 1% owned a staggering 34% of financial wealth.⁷⁷ Should we really be rushing to reallocate money from home health aides, nurses, physicians, pharmacists, dentists, and drug researchers to the small fraction of Americans who own most financial assets?

Some of those with the most financial wealth are using their resources to promote political programs that advocate for slashing Medicare and Medicaid to "cut the deficit," while they rarely, if ever, broach the possibility of taxing the wealthiest at rates that prevailed in the United States as recently as the 1950s.⁷⁸ Initiatives to cut health care costs are often less a neutral, technocratic project of rationalizing public expenditure than one cog in a larger machine of upward wealth redistribution: away from patients and professionals on the frontlines of care, to an investor class that can pay for the best health care in the world without any public help or insurance pool to supplement their purchasing power.

Popular as it may be among technocrats, the deficit reduction narrative has already failed once before. Former President Bill Clinton helped engineer a balanced budget in the late 1990s, and even experienced a federal budget surplus. The next administration promptly squandered that money on tax cuts

76. See David U. Himmelstein & Steffie Woolhandler, *The Regressivity of Taxing Employer-Paid Health Insurance*, 361 NEW ENG. J. MED. e101, e101 (2009).

77. G. William Domhoff, *Wealth, Income, and Power*, at <http://www2.ucsc.edu/whorulesamerica/power/wealth.html>. On this page, *Figure 1: Net worth and financial wealth distribution in the U.S. in 2010* shows that the top 10% of households (with a mean net worth of about \$2 million) have 85% of financial wealth in the United States. *Id.* Wealth has only become more concentrated since then.

78. Such programs include Fix the Debt, The Can Kicks Back, or others from the billionaire Pete Peterson's Institute for International Economics. See FIX THE DEBT, <http://www.fixthedebt.org/> (last visited July 27, 2014); THE CAN KICKS BACK, <http://www.thecankicksback.org/> (last visited July 27, 2014).

primarily benefitting the wealthiest and, a bit later, a multitrillion dollar commitment in Iraq. If the ACA does manage to cut federal health care budgets by 2020, America may well see surpluses again turned into deficits in ill-fated military campaigns. Simply “cutting deficits,” without some positive and durable sense of where the money is going, merely gives hostages to fortune.

It would be far better to redirect current energies in health care cost-cutting toward *quality improvement*, which would both cut wasteful spending and redirect that saved money (and perhaps other funds) to the multiple underserved populations now documented in health disparities literatures, and the many initiatives in personalized medicine, health IT, and medical research that are now inadequately funded. For example, the United States is rapidly running out of effective antibiotics, leading some experts to worry about the advent of a postantibiotic era where minor wounds could spiral into long hospital stays, or even death, for those infected with drug-resistant microbes.⁷⁹ Spending more on antibiotic research now could prevent far more costs in the future.

It is not just drug research that suffers in a health austerity regime. Governmental refusals to pay for current drugs may backfire, too.⁸⁰ If a high co-pay leads a congestive heart failure patient to skip critical medications, she might end up in an emergency department—a far costlier intervention. Finally, the recent rise of drug shortages should be a cautionary tale for anyone hoping that market forces will enforce just-in-time production patterns that minimize costs in other industries.⁸¹ A disrupted supply chain in car parts can cause remediable inconvenience. Shortages of critical drugs, by contrast, threaten to impose irreparable harm on those in need of treatment while rationing (or improvisation with second-best treatment regimens) must occur.

B. Health Macroeconomics

The health care sector is also anchoring the economic future of many regions. For many American urbanists and economic planners, the keys to the future of growth are “meds and eds.” Cities and regions with thriving universities and hospitals could emulate Pittsburgh, Ann Arbor, and other cities which have bounced back from manufacturing’s decline. On this vision,

79. See Tom Worstall, *Why We’re Running Out of Antibiotics is an Economic Problem, Not a Medical or Pharmaceutical One*, FORBES (MAY 3, 2014, 12:15 PM), <http://www.forbes.com/sites/timworstall/2014/05/03/why-were-running-out-of-antibiotics-is-an-economic-problem-not-a-medical-or-pharmaceutical-one/>; Anita Manning, ‘Superbugs’ Spread Fear Far and Wide, USA TODAY, May 11, 2006, at A1.

80. Joel Lexchin, Prescribing Errors, 172 CMAJ 1503, 1504 (2005) (“[W]hen New Hampshire put a cap on the monthly number of prescriptions that welfare recipients would get for free, the result was an increase in nursing home admissions that probably cost the state government as much as it saved on drug costs.”).

81. Sharona Hoffman, *The Drugs Stop Here: A Public Health Framework to Address the Drug Shortage Crisis*, 67 FOOD AND DRUG L.J. 1, 4–5 (2012).

decently paid human services in the medical and education sectors could sustain employment and spark innovation.

George Mason University economist Tyler Cowen offers a radically different vision in his recent book *Average Is Over*, revealing a troubling endgame for neoliberal health cost cutting.⁸² For Cowen, current trends toward economic inequality will swamp the meds and eds trend. There will be a prosperous class of the top ten or fifteen percent of society making over one million dollars a year, and a huge underclass with far fewer resources than the median household of today. Asked by a skeptical radio journalist how this transition would transpire in the United States without mass resistance or discontent, he nonchalantly points to income levels prevailing in poorer precincts of Latin America as a potential equilibrium point for the broad American middle class.⁸³ Pressed to discuss the possibility of redistribution, Cowen dismissed it, pointing to the quiescence of the average U.S. citizen and the increasing influence of the very wealthy over the political process.⁸⁴ Instead, he has urged policymakers to focus their attention on reducing the costs of health care and education, in order to preserve some level of access to these necessities to a radically poorer middle class.

Cowen frames his position as a tough realism, a reluctant recognition of hard economic realities of scarcity. Yet there are many contestable links in the chains of causation that health care cost-cutters would use to justify binding the growth of health care spending. As long as there are hundreds of U.S. billionaires, thousands of hecto-millionaires, and trillions of dollars hidden offshore, throwing off untold (and improperly untaxed) sums for their wily owners, some funds are available to cover health cost overruns. America's top one percent—enjoying over ninety percent of economic gains for years now, and a vastly disproportionate share of economic growth since 1980—cannot forever keep accumulating wealth without returning some fair share to accommodate the needs of the other 99%.

The more foresighted among them must also realize that, at the end of the day, the most important threats to their own well-being—debilitating sicknesses, in the form of either acute or chronic disease—can only be

82. See TYLER COWEN, *AVERAGE IS OVER: POWERING AMERICA BEYOND THE AGE OF THE GREAT STAGNATION* (2013); Tyler Cowen, *Our Economic Problems Are in Sectors, Not the System*, N.Y. TIMES, June 17, 2014, available at <http://www.nytimes.com/roomfordebate/2014/03/30/was-marx-right/our-economic-problems-are-in-sectors-not-the-system> (describing a “health care system which combines the worst properties of public and private sector incentives, leading to more expensive service and lower quality and access”).

83. *Economist* Tyler Cowen on the End of Average, ON POINT (Sept. 16, 2013), <http://onpoint.wbur.org/2013/09/16/economist-tyler-cowen-on-the-end-of-average>.

84. *Id.* Operating from a very different set of assumptions, Sheldon Wolin would probably come to a similar conclusion. See Sheldon Wolin, *Inverted Totalitarianism: How the Bush Regime is Effecting the Transformation to a Fascist-Like State*, NATION, (May 1, 2003), <http://www.thenation.com/article/inverted-totalitarianism#> (“[I]nverted totalitarianism wants a politically demobilized society that hardly votes at all.”).

alleviated, deflected, or delayed. Having hundreds of times more wealth than others is no route to a life hundreds of times longer. Indeed, the opposite may well be true: The uncared-for poor may be more likely to harbor or spread antibiotic-resistant microbes or viral contagions to others than they would be if they received adequate and timely health care. To the extent it worsens the fate of the one percent, health care cost-cutting may be a lose-lose game. Out-of-control contagions would swamp whatever welfare gains the wealthy enjoy from persuading politicians to cut their taxes.

Even if gated communities can guard the very wealthy from contagious disease, the upper classes still will need to rely on a larger health care system sustained by mass participation and demand. It is hard to imagine individuals, or even wealthy groups, stockpiling all drugs they might need, particularly the sterile injectables or biotech solutions that are critical to advanced medicine. Even the very wealthy must rely on a steady, more general demand for these products. They cannot just order them for instant delivery via Amazon. Public subvention—ranging from research grants to Medicare and Medicaid funding for the products research generates—provides that demand. Cutting it by providing ever-more tax breaks for the wealthy is an astonishingly short-sighted strategy, even for the richest.

V

CONCLUSION

Cost-cutting is a conveniently flexible *summum bonum* that can hide the often brutally reallocative measures taken to financialize health systems (that is, to maximize their ability to deliver returns to investors) or tier them (in order to stratify quality and availability of care on the basis of ability and willingness to pay). If the health care cost-cutters had a plan for reallocating excess health sector spending to pay for care that is now undercompensated or absent, they would merit the influence they have now achieved. But in reality, money freed up by cost-cutting is much more likely to be retained as profit or claimed by capital and rentiers in some other way. The “customer” for many private insurers is the *corporation* buying coverage for its employees, not the employees themselves (the insured). Reduce the cost of such insurance in an era of mass un- and under-employment, and guess who will capture those funds? One does not need to read Kalecki to guess which way the money flows.

The cost-containment consensus obscures these unpleasant realities. It is an ideological touchstone of U.S. health care and key to reducing the field to a technocratic object. Establishment economists alarmingly pronounce on the horrors of spending over seventeen percent of GDP on health care, ignoring the repeated falsifications of predictions of doom when health expenditures as a percentage of GDP passed other, arbitrary thresholds. Health policymakers nevertheless tend to accept that framing, and busy themselves with finding the most wasteful providers. They rarely consider whether the outlier dermatologist

making \$900,000 a year is as much of a misallocation of resources as, say, the hedge fund managers making hundreds of millions of dollars in a single year, or ever more richly compensated top managers and private equity firms.⁸⁵ A goodly number of billionaires richly fund austerity-promoting think tanks that keep public debates focused on cost-cutting, rather than fairer pay for undercompensated health workers.

Technocrats may cast my arguments as a “rhetoric of reaction” that overemphasizes the perverse and futile consequences of cost-cutting, unfairly occluding its more positive effects.⁸⁶ But the question of emphasis may just as easily be reversed. In their eagerness to “rationalize” the health-delivery system, cost-cutters overlook (and threaten to wreck) the delicate ecology of current health care finance. My conservatism merely turns the rationalizing impulse of cost-cutting on itself: demanding that neoliberals show more evidence of the success of cost-cutting before erecting ever higher burdens of documentation (or ill-considered incentive schemes) for health care providers.⁸⁷

Cost-cutters constantly evoke waste and fraud as their targets, but their program also has real human costs. In *The Body Economic*, David Stuckler and Sanjay Basu demonstrate that endless pressure to cut public spending—including health spending—has directly impacted life expectancy in Europe’s periphery.⁸⁸ In the United States, new data shows that in many areas, white women’s life expectancy has gone down by close to *five years*.⁸⁹ Once insurance and care become scarce or burdensome to seek out, people who are sickened by lack of health insurance, or are too hard-pressed to participate in politics, are in no position to fight back against the austerity juggernaut. Nor are they able to fight effectively for one policy that would have a decent chance of cutting costs while improving quality: a public option like Medicare for anyone without decent employer coverage.

Having dismissed such real reforms as utopian nullities, neoliberals’ preferred brand of “cost-cutting” continues to dominate American health policy. The longer it holds sway, the more profit-driven, rather than patient-driven, care promises to dominate the health care landscape. Financiers will

85. LAWRENCE MISHEL & ALYSSA DAVIS, ECON. POLICY INST., CEO PAY CONTINUES TO RISE AS TYPICAL WORKERS ARE PAID LESS (June 12, 2014).

86. ALBERT O. HIRSCHMAN, *THE RHETORIC OF REACTION: PERVERSITY, FUTILITY, JEOPARDY* (1991).

87. As G.A. Cohen has observed, “with historical working class gains in place, small-c conservatism becomes a buffer against inequality. For the sake of protecting and extending the powers of wealth, big-C Conservatives [i.e., members of parties of the right] regularly sacrifice the small-c conservatism that many of them genuinely cherish.” G.A. Cohen, *A Truth in Conservatism: Rescuing Conservatism from the Conservatives* 35 (A1-2004 Conservatism Workshop, 2004), available at https://politicalscience.stanford.edu/sites/default/files/workshop-materials/pt_cohen.pdf.

88. See generally DAVID STUCKLER & SANJAY BASU, *THE BODY ECONOMIC: WHY AUSTERITY KILLS* (2013).

89. Emily Shire, *The Mysterious Decline in Female Life Expectancy*, *THE WEEK* (Oct. 9, 2013), <http://theweek.com/article/index/250795/the-mysterious-decline-in-female-life-expectancy>.

continue to wrest more control of the sector from physicians, nurses, scientists, and other frontline innovators and providers of care. Without a far more textured analysis of how dollars now devoted to health care can be *better* spent, rather than merely *not* spent, a dark future of stratification and deprofessionalization is all but assured.

There is an alternative. Direct state investment in new technologies would advance all three of the “triple aims” of health policy (cost containment, enhancement of quality, and expanding access to care).⁹⁰ Fully funding the Food and Drug Administration would help identify which interventions really work and which are mere money-spinners.⁹¹ Gradually expanding Medicare eligibility could lead to real competition for the private plans now offered on the ACA’s exchanges. Investment in learning health care systems and health data interoperability would provide a better infrastructure for medical research. Extensive training programs and fairer pay could lead to true professionalization of home health aides—workers now burdened with generally low pay and dismal prospects for career advancement.

These goals may seem unrealistic now. But until our health policymakers directly aim for them, we will be at the mercy of a cost-containment model as flawed as pre-Copernican, geocentric astronomy. We can continue to add epicycles of exchanges, subsidies, risk corridors, navigators, clawbacks, and auditors to paper over the flaws in this neoliberal model of “health reform.” Or we can invest directly in patient-centered care. It may not cut costs, but over the long term, what could better assure Americans’ productivity and well-being?

90. See generally MARIANA MAZZUCATO, *THE ENTREPRENEURIAL STATE: DEBUNKING PUBLIC VS. PRIVATE SECTOR MYTHS* (2013).

91. See BEN GOLDACRE, *BAD PHARMA: HOW DRUG COMPANIES MISLEAD DOCTORS AND HARM PATIENTS* 1–11 (2012) (discussing the problems associated with industry-funded testing); Frank Pasquale, *Grand Bargains for Big Data: The Emerging Law of Health Information*, 72 MD. L. REV. 668–772 (collecting studies on secrecy in the health context).
