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After the needless death of his father, the author, a business executive, began a personal exploration of a health-care industry that for years has delivered poor service and irregular quality at astonishingly high cost. It is a system, he argues, that is not worth preserving in anything like its current form. And the health-care reform now being contemplated will not fix it. Here's a radical solution to an agonizing problem.

by David Goldhill

How American Health Care Killed My Father

ALMOST TWO YEARS ago, my father was killed by a hospital-borne infection in the intensive-care unit of a well-regarded nonprofit hospital in New York City. Dad had just turned 83, and he had a variety of the ailments common to men of his age. But he was still working on the day he walked into the hospital with pneumonia. Within 36 hours, he had developed sepsis. Over the next five weeks in the ICU, a wave of secondary infections, also acquired in the hospital, overwhelmed his defenses. My dad became a statistic—merely one of the [roughly 100,000 Americans](#) whose deaths are caused or influenced by infections picked up in hospitals. One hundred thousand deaths: more than double the number of people killed in car crashes, five times the number killed in homicides, 20 times the total number of our armed forces killed in Iraq and Afghanistan. Another victim in a building American tragedy.



Illustration by Mark Hooper

About a week after my father's death, *The New Yorker* ran an [article by Atul Gawande](#) profiling the efforts of Dr. Peter Pronovost to reduce the incidence of fatal hospital-borne infections. Pronovost's solution? A simple checklist of ICU protocols governing physician hand-washing and other basic sterilization procedures. Hospitals implementing Pronovost's checklist had enjoyed almost instantaneous success, reducing hospital-infection rates by two-thirds within the first three months of its adoption. But many physicians rejected the checklist as an unnecessary and belittling bureaucratic intrusion, and many hospital executives were reluctant to push it on them. The story chronicled Pronovost's travels around the country as he struggled to persuade hospitals to embrace his reform.

It was a heroic story, but to me, it was also deeply unsettling. How was it possible that Pronovost needed to beg hospitals to adopt an essentially cost-free idea that saved so many lives? Here's an industry that loudly protests the high cost of liability insurance and the injustice of our tort system and yet needs extensive lobbying to embrace a simple technique to save up to 100,000 people.

And what about us—the patients? How does a nation that might close down a business for a single illness from a suspicious hamburger tolerate the carnage inflicted by our hospitals? And not just those 100,000 deaths. In April, a [Wall Street Journal story](#) suggested that blood clots following surgery or illness, the leading cause of preventable hospital deaths in the U.S., may

kill nearly 200,000 patients per year. How did Americans learn to accept hundreds of thousands of deaths from minor medical mistakes as an inevitability?

My survivor's grief has taken the form of an obsession with our health-care system. For more than a year, I've been reading as much as I can get my hands on, talking to doctors and patients, and asking a lot of questions.

Keeping Dad company in the hospital for five weeks had left me befuddled. How can a facility featuring state-of-the-art diagnostic equipment use less-sophisticated information technology than my local sushi bar? How can the ICU stress the importance of sterility when its trash is picked up once daily, and only after flowing onto the floor of a patient's room? Considering the importance of a patient's frame of mind to recovery, why are the rooms so cheerless and uncomfortable? In whose interest is the bizarre scheduling of hospital shifts, so that a five-week stay brings an endless string of new personnel assigned to a patient's care? Why, in other words, has this technologically advanced hospital missed out on the revolution in quality control and customer service that has swept all other consumer-facing industries in the past two generations?

I'm a businessman, and in no sense a health-care expert. But the persistence of bad industry practices—from long lines at the doctor's office to ever-rising prices to astonishing numbers of preventable deaths—seems beyond all normal logic, and must have an underlying cause. There needs to be a *business reason* why an industry, year in and year out, would be able to get away with poor customer service, unaffordable prices, and uneven results—a reason my father and so many others are unnecessarily killed.

Like every grieving family member, I looked for someone to blame for my father's death. But my dad's doctors weren't incompetent—on the contrary, his hospital physicians were smart, thoughtful, and hard-working. Nor is he dead because of indifferent nursing—without exception, his nurses were dedicated and compassionate. Nor from financial limitations—he was a Medicare patient, and the issue of expense was never once raised. There were no greedy pharmaceutical companies, evil health insurers, or other popular villains in his particular tragedy.

Indeed, I suspect that our collective search for villains—for someone to blame—has distracted us and our political leaders from addressing the fundamental causes of our nation's health-care crisis. All of the actors in health care—from doctors to insurers to pharmaceutical companies—work in a heavily regulated, massively subsidized industry full of structural distortions. They all want to serve patients well. But they also all behave rationally in response to the economic incentives those distortions create. Accidentally, but relentlessly, America has built a health-care system with incentives that inexorably generate terrible and perverse results. Incentives that emphasize health *care* over any other aspect of health and well-being. That emphasize treatment over prevention. That disguise true costs. That favor complexity, and discourage transparent competition based on price or quality. That result in a generational pyramid scheme rather than sustainable financing. And that—most important—remove consumers from our irreplaceable role as the ultimate insurer of value.

These are the impersonal forces, I've come to believe, that explain why things have gone so badly wrong in health care, producing the national dilemma of runaway costs and poorly covered millions. The problems I've explored in the past year hardly count as breakthrough discoveries—health-care experts undoubtedly view all of them as old news. But some experts, it seems, have come to see many of these problems as inevitable in any health-care system—as conditions to be patched up, papered over, or worked around, but not problems to be solved.

That's the premise behind today's incremental approach to health-care reform. Though details of the legislation are still being negotiated, its principles are a reprise of previous reforms—addressing access to health care by expanding government aid to those without adequate insurance, while attempting to control rising costs through centrally administered initiatives. Some of the ideas now on the table may well be sensible in the context of our current system. But fundamentally, the

“comprehensive” reform being contemplated merely cements in place the current system—insurance-based, employment-centered, administratively complex. It addresses the underlying causes of our health-care crisis only obliquely, if at all; indeed, by extending the current system to more people, it will likely increase the ultimate cost of true reform.

I’m a Democrat, and have long been concerned about America’s lack of a health safety net. But based on my own work experience, I also believe that unless we fix the problems at the foundation of our health system—largely problems of incentives—our reforms won’t do much good, and may do harm. To achieve maximum coverage at acceptable cost with acceptable quality, health care will need to become subject to the same forces that have boosted efficiency and value throughout the economy. We will need to reduce, rather than expand, the role of insurance; focus the government’s role exclusively on things that only government can do (protect the poor, cover us against true catastrophe, enforce safety standards, and ensure provider competition); overcome our addiction to Ponzi-scheme financing, hidden subsidies, manipulated prices, and undisclosed results; and rely more on ourselves, the consumers, as the ultimate guarantors of good service, reasonable prices, and sensible trade-offs between health-care spending and spending on all the other good things money can buy.

These ideas stand well outside the emerging political consensus about reform. So before exploring alternative policies, let’s reexamine our basic assumptions about health care—what it actually is, how it’s financed, its accountability to patients, and finally its relationship to the eternal laws of supply and demand. Everyone I know has at least one personal story about how screwed up our health-care system is; before spending (another) \$1trillion or so on reform, we need a much clearer understanding of the causes of the problems we all experience.

HEALTH CARE ISN’T HEALTH (OR HAPPINESS)

“Money is honey,” my grandmother used to tell me, “but health is wealth.” She said “health,” not “health care.” Listening to debates over health-care reform, it is sometimes difficult to remember that there is a difference.

Medical care, of course, is merely one component of our overall health. Nutrition, exercise, education, emotional security, our natural environment, and public safety may now be more important than care in producing further advances in longevity and quality of life. (In 2005, almost half of all deaths in the U.S. resulted from heart disease, diabetes, lung cancer, homicide, suicide, and accidents—all of which are arguably influenced as much by lifestyle choices and living environment as by health care.) And of course even health itself is only one aspect of personal fulfillment, alongside family and friends, travel, recreation, the pursuit of knowledge and experience, and more.

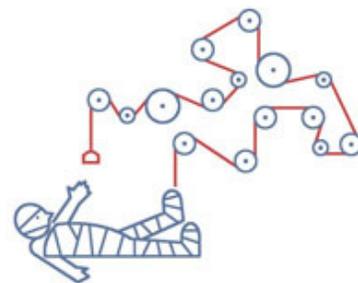


Illustration by Stephen Savage

Yet spending on health care, by families and by the government, is crowding out spending on almost everything else. As a nation, [we now spend almost 18 percent](#) of our GDP on health care. In 1966, Medicare and Medicaid made up 1 percent of total government spending; now that figure is 20 percent, and [quickly rising](#). Already, the federal government spends eight times as much on health care as it does on education, 12 times what it spends on food aid to children and families, 30 times what it spends on law enforcement, 78 times what it spends on land management and conservation, 87 times the spending on water supply, and 830 times the spending on energy conservation. Education, public safety, environment, infrastructure—all other public priorities are being slowly devoured by the health-care beast.

It’s no different for families. From 2000 to 2008, the [U.S. economy grew](#) by \$4.4 trillion; of that growth, roughly one out of every four dollars was spent on health care. Household expenditures on health care already exceed those on housing. And health care’s share is growing.

By what mechanism does society determine that an extra, say, \$100 billion for health care will make us healthier than even \$10 billion for cleaner air or water, or \$25 billion for better nutrition, or \$5 billion for parks, or \$10 billion for recreation, or \$50 billion in additional vacation time—or all of those alternatives combined?

The answer is, no mechanism at all. Health care simply keeps gobbling up national resources, seemingly without regard to other societal needs; it's treated as an island that doesn't touch or affect the rest of the economy. As new tests and treatments are developed, they are, for the most part, added to our Medicare or commercial insurance policies, no matter what they cost. But of course the money must come from somewhere. If the amount we spend on care had grown only at the general rate of inflation since 1970, annual health-care costs now would be roughly \$5,000 less per American—that's about 10 percent of today's median income, to invest for the future or to spend on all the other things that contribute to our well-being. To be sure, our society has become wealthier over the years, and we'd naturally want to spend some of this new wealth on more and better health care; but how did we choose to spend this much?

The housing bubble offers some important lessons for health-care policy. The claim that something—whether housing or health care—is an undersupplied social good is commonly used to justify government intervention, and policy makers have long striven to make housing more affordable. But by making housing investments eligible for special tax benefits and subsidized borrowing rates, the government has stimulated not only the construction of more houses but also the willingness of people to borrow and spend more on houses than they otherwise would have. The result is now tragically clear.

As with housing, directing so much of society's resources to health care is stimulating the provision of vastly more care. Along the way, it's also distorting demand, raising prices, and making us all poorer by crowding out other, possibly more beneficial, uses for the resources now air-dropped onto the island of health care. Why do we view health care as disconnected from everything else? Why do we spend so much on it? And why, ultimately, do we get such inconsistent results? Any discussion of the ills within the system must begin with a hard look at the tax-advantaged comprehensive-insurance industry at its center.

HEALTH INSURANCE ISN'T HEALTH CARE

How often have you heard a politician say that millions of Americans “have no health care,” when he or she meant they have no health *insurance*? How has a method of financing health care become synonymous with care itself?

The reason for financing at least some of our health care with an insurance system is obvious. We all worry that a serious illness or an accident might one day require urgent, extensive care, imposing an extreme financial burden on us. In this sense, health-care insurance is just like all other forms of insurance—life, property, liability—where the many who face a risk share the cost incurred by the few who actually suffer a loss.

But health insurance is different from every other type of insurance. Health insurance is the primary payment mechanism not just for expenses that are unexpected and large, but for *nearly all* health-care expenses. We've become so used to health insurance that we don't realize how absurd that is. We can't imagine paying for gas with our auto-insurance policy, or for our electric bills with our homeowners insurance, but we all assume that our regular checkups and dental cleanings will be covered at least partially by insurance. Most pregnancies are planned, and deliveries are predictable many months in advance, yet they're financed the same way we finance fixing a car after a wreck—through an insurance claim.

Comprehensive health insurance is such an ingrained element of our thinking, we forget that its rise to dominance is relatively recent. Modern group health insurance was introduced in 1929, and employer-based insurance began to blossom during World War II, when wage freezes prompted employers to expand other benefits as a way of attracting workers. Still, as late as 1954, only a minority of Americans had health insurance. That's when Congress passed a law making employer contributions to employee health plans tax-deductible without making the resulting benefits taxable to employees. This

seemingly minor tax benefit not only encouraged the spread of catastrophic insurance, but had the accidental effect of making employer-funded health insurance the most affordable option (after taxes) for financing pretty much *any* type of health care. There was nothing natural or inevitable about the way our system developed: employer-based, comprehensive insurance crowded out alternative methods of paying for health-care expenses only because of a poorly considered tax benefit passed half a century ago.

In designing Medicare and Medicaid in 1965, the government essentially adopted this comprehensive-insurance model for its own spending, and by the next year had enrolled nearly 12 percent of the population. And it is no coincidence that the great inflation in health-care costs began soon after. We all believe we need comprehensive health insurance because the cost of care—even routine care—appears too high to bear on our own. But the use of insurance to fund virtually all care is itself a major *cause* of health care's high expense.

Insurance is probably the most complex, costly, and distortional method of financing any activity; that's why it is otherwise used to fund only rare, unexpected, and large costs. Imagine sending your weekly grocery bill to an insurance clerk for review, and having the grocer reimbursed by the insurer to whom you've paid your share. An expensive and wasteful absurdity, no?

Is this really a big problem for our health-care system? Well, for every two doctors in the U.S., there is now one health-insurance employee—more than 470,000 in total. In 2006, it cost almost \$500 per person just to administer health insurance. Much of this enormous cost would simply disappear if we paid routine and predictable health-care expenditures the way we pay for everything else—by ourselves.

THE MORAL-HAZARD ECONOMY

Society's excess cost from health insurance's administrative expense pales next to the damage caused by "moral hazard"—the tendency we all have to change our behavior, becoming spendthrifts and otherwise taking less care with our decisions, when someone else is covering the costs. Needless to say, much medical care is unavoidable; we don't choose to become sick, nor do we seek more treatment than we think we need. Still, hospitals, drug companies, health insurers, and medical-device manufacturers now spend roughly \$6 billion a year on advertising. If the demand for health care is purely a response to unavoidable medical need, why do these companies do so much advertising?

[Medical ads on TV](#) typically inform the viewer that a specific treatment—a drug, device, surgical procedure—is available for a chronic condition. Many also note that the product or treatment is eligible for Medicare or private-insurance reimbursement. In some cases, the advertiser will offer to help the patient obtain that reimbursement. The key message: you can benefit from this product and pass the bill on to someone else.

Every time you walk into a doctor's office, it's implicit that someone else will be paying most or all of your bill; for most of us, that means we give less attention to prices for medical services than we do to prices for anything else. Most physicians, meanwhile, benefit financially from ordering diagnostic tests, doing procedures, and scheduling follow-up appointments. Combine these two features of the system with a third—the informational advantage that extensive training has given physicians over their patients, and the authority that advantage confers—and you have a system where physicians can, to some extent, generate demand at will.

Do they? Well, [Medicare spends almost twice as much per patient in Dallas](#), where there are more doctors and care facilities

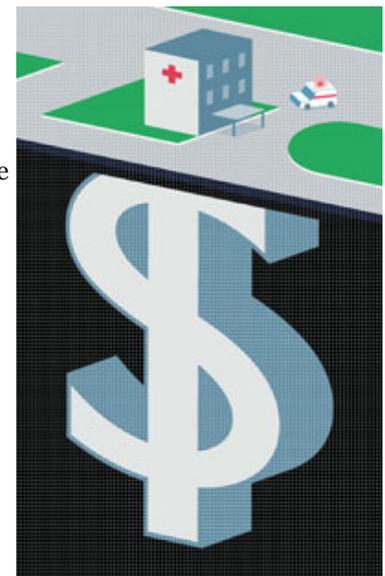


Illustration by Stephen Savage

per resident, as it does in Salem, Oregon, where supply is tighter. Why? Because doctors (particularly specialists) in surplus areas order more tests and treatments per capita, and keep their practices busy. Many studies have shown that the patients in areas like Dallas do not benefit in any measurable way from all this extra care. All of the physicians I know are genuinely dedicated to their patients. But at the margin, all of us are at least subconsciously influenced by our own economic interests. The data are clear: in our current system, physician supply often begets patient demand.

Moral hazard has fostered an accidental collusion between providers benefiting from higher costs and patients who don't fully bear them. In this environment, trying to control costs is awfully tough. When Medicare cut reimbursement rates in 2005 on chemotherapy and anemia drugs, for instance, it saved almost 20 percent of the previously billed costs. But Medicare's total cancer-treatment costs actually rose almost immediately. As *The New York Times* reported, some physicians believed their colleagues simply performed more treatments, particularly higher-profit ones.

Want further evidence of moral hazard? The average insured American and the average uninsured American spend very similar amounts *of their own money* on health care each year—\$654 and \$583, respectively. But they spend wildly different amounts *of other people's money*—\$3,809 and \$1,103, respectively. Sometimes the uninsured do not get highly beneficial treatments because they cannot afford them at today's prices—something any reform must address. But likewise, insured patients often get only marginally beneficial (or even outright unnecessary) care at mind-boggling cost. If it's true that the insurance system leads us to focus on only our direct share of costs—rather than the total cost to society—it's not surprising that insured families and uninsured ones would make similar decisions as to how much of their own money to spend on care, but very different decisions on the total amount to consume.

The unfortunate fact is, health-care demand has no natural limit. Our society will always keep creating new treatments to cure previously incurable problems. Some of these will save lives or add productive years to them; many will simply make us more comfortable. That's all to the good. But the cost of this comfort, and whether it's really worthwhile, is never calculated—by anyone. For almost all our health-care needs, the current system allows us as consumers to ask providers, "What's my share?" instead of "How much does this cost?"—a question we ask before buying any other good or service. And the subtle difference between those two questions is costing us all a fortune.

THERE'S NO ONE ELSE TO PAY THE BILL

Perhaps the greatest problem posed by our health-insurance-driven regime is the sense it creates that someone else is actually paying for most of our health care—and that the costs of new benefits can also be borne by someone else. Unfortunately, there is no one else.

For fun, let's imagine confiscating all the profits of all the famously greedy health-insurance companies. That would pay for four days of health care for all Americans. Let's add in the profits of the 10 biggest rapacious U.S. drug companies. Another 7 days. Indeed, confiscating all the profits of *all* American companies, in *every* industry, wouldn't cover even five months of our health-care expenses.

Somebody else always *seems* to be paying for at least part of our health care. But that's just an illusion. At \$2.4 trillion and growing, our nation's health-care bill is too big to be paid by anyone other than all of us.

In 2007, employer-based health insurance cost, on average, more than \$12,000 per family, up 78 percent since 2001. I've run several companies and company divisions of various sizes over the course of my career, so I can confidently tell you that raises (and even entry-level hiring) are tightly limited by rising health-care costs. You may think your employer is paying for your health care, but in fact your company's share of the insurance premium comes out of your potential wage increase. Where else *could* it come from?

Let's say you're a 22-year-old single employee at my company today, starting out at a \$30,000 annual salary. Let's assume you'll get married in six years, support two children for 20 years, retire at 65, and die at 80. Now let's make a crazy assumption: insurance premiums, Medicare taxes and premiums, and out-of-pocket costs will grow no faster than your earnings—say, 3 percent a year. By the end of your working days, your annual salary will be up to \$107,000. And over your lifetime, you and your employer together will have paid \$1.77 million for your family's health care. \$1.77 million! And that's only after assuming the taming of costs! In recent years, health-care costs have actually grown 2 to 3 percent faster than the economy. If that continues, your 22-year-old self is looking at an additional \$2 million or so in expenses over your lifetime—roughly \$4 million in total.

Would you have guessed these numbers were so large? If not, you have good cause: only a quarter would be paid by you directly (and much of that after retirement). The rest would be spent by others on your behalf, deducted from your earnings before you received your paycheck. And that's a big reason why our health-care system is so expensive.

THE GOVERNMENT IS NOT GOOD AT COST REDUCTION

Every proposal for health-care reform has featured some element of cost control to “balance” the inflationary impact of expanding access. Yet it goes without saying that in the big picture, all government efforts to control costs have failed.

Why? One reason is a fixation on prices rather than costs. The government regularly tries to cap costs by limiting the reimbursement rates paid to providers by Medicare and Medicaid, and generally pays much less for each service than private insurers. But as we've seen, that can lead providers to perform *more* services, and to steer patients toward higher-priced, more lightly regulated treatments. The government's efforts to expand “access” to care while limiting costs are like blowing up a balloon while simultaneously squeezing it. The balloon continues to inflate, but in misshapen form.

Cost control is a feature of decentralized, competitive markets, not of centralized bureaucracy—a matter of incentives, not mandates. What's more, cost control is *dynamic*. Even the simplest business faces constant variation in its costs for labor, facilities, and capital; to compete, management must react quickly, efficiently, and, most often, prospectively. By contrast, government bureaucracies set regulations and reimbursement rates through carefully evaluated and broadly applied rules. These bureaucracies first must notice market changes and resource misallocations, and then (sometimes subject to political considerations) issue additional regulations or change reimbursement rates to address each problem retrospectively.

As a result, strange distortions crop up constantly in health care. For example, although the population is rapidly aging, [we have few geriatricians](#)—physicians who address the cluster of common patient issues related to aging, often crossing traditional specialty lines. Why? Because under Medicare's current reimbursement system (which generally pays more to physicians who do lots of tests and procedures), geriatricians typically don't make much money. If seniors were the true customers, they would likely flock to geriatricians, bidding up their rates—and sending a useful signal to medical-school students. But Medicare is the real customer, and it pays more to specialists in established fields. And so, seniors often end up overusing specialists who are not focused on their specific health needs.

Many reformers believe if we could only adopt a single-payer system, we could deliver health care more cheaply than we do today. The experience of other developed countries suggests that's true: the government as single payer would have lower administrative costs than private insurers, as well as enormous market clout and the ability to bring down prices, although at the cost of explicitly rationing care.

But even leaving aside the effects of price controls on innovation and customer service, today's Medicare system should leave us skeptical about the long-term viability of that approach. From 2000 to 2007, despite its market power, Medicare's hospital and physician reimbursements per enrollee rose by 5.4 percent and 8.5 percent, respectively, per year. As currently

structured, Medicare is a Ponzi scheme. The Medicare tax rate has been raised seven times since its enactment, and almost certainly will need to be raised again in the next decade. The Medicare tax contributions and premiums that today's beneficiaries have paid into the system don't come close to fully funding their care, which today's workers subsidize. The subsidy is getting larger even as it becomes more difficult to maintain: next year there will be 3.7 working people for each Medicare beneficiary; if you're in your mid-40s today, there will be only 2.4 workers to subsidize your care when you hit retirement age. The experience of other rich nations should also make us skeptical. Whatever their histories, nearly all developed countries are now struggling with rapidly rising health-care costs, including those with single-payer systems. From 2000 to 2005, per capita health-care spending in Canada grew by 33 percent, in France by 37 percent, in the U.K. by 47 percent—all comparable to the 40 percent growth experienced by the U.S. in that period. Cost control by way of bureaucratic price controls has its limits.

UNCOMPETITIVE

In 2007, health companies in the *Fortune* 1,000 earned \$71 billion. Of the 52 industries represented on *Fortune*'s list, pharmaceuticals and medical equipment ranked third and fourth, respectively, in terms of profits as a share of revenue. From 2000 to 2007, the annual profits of America's top 15 health-insurance companies increased from \$3.5 billion to \$15 billion.

In competitive markets, high profits serve an important social purpose: encouraging capital to flow to the production of a service not adequately supplied. But as long as our government shovels ever-greater resources into health care with one hand, while with the other restricting competition that would ensure those resources are used efficiently, sustained high profits will be the rule.

Health care is an exceptionally heavily regulated industry. Health-insurance companies are regulated by states, which limits interstate competition. And many of the materials, machines, and even software programs used by health-care facilities must be licensed by state or federal authorities, or approved for use by Medicare; these requirements form large barriers to entry for both new facilities and new vendors that could equip and supply them.

Many health-care regulations are justified as safety precautions. But many also result from attempts to redress the distortions that our system of financing health care has created. And whatever their purpose, almost all of these regulations can be shaped over time by the powerful institutions that dominate the health-care landscape, and that are often looking to protect themselves from competition.

Take the ongoing battle between large integrated hospitals and specialty clinics (for cardiac surgery, orthopedics, maternity, etc.). The economic threat posed by these facilities is well illustrated by a recent battle in Loma Linda, California. When a group of doctors proposed a 28-bed private specialty facility, the local hospitals protested to the city council that it was unnecessary, and launched a publicity campaign to try to block it; [the council backed the facility anyway](#). So the nonprofit Loma Linda University Medical Center simply bought the new facility for \$80 million in 2008. Traditional hospitals got Congress to include an 18-month moratorium on new specialty hospitals in [the 2003 Medicare law](#), and a second six-month ban in 2005.

The hospitals' argument has some merit: less complicated surgical cases (the kind specialty clinics typically take on) tend to be more profitable than complex surgeries and nonsurgical admissions. Without those profitable cases, hospitals can't subsidize the cases on which they lose money. But why are simple surgeries more profitable? Because of the nonmarket methods by which Medicare sets prices.

The net effect of the endless layers of health-care regulation is to stifle competition in the classic economic sense. What we

have instead is a noncompetitive system where services and reimbursement are negotiated above consumers' heads by large private and government institutions. And the primary goal of any large noncompetitive institution is not cost control or product innovation or customer service: it's maintenance of the status quo.

OUR FAVORED HOSPITALS

In 1751, Benjamin Franklin and Dr. Thomas Bond founded Pennsylvania Hospital, the first in America, "to care for the sick-poor and insane who were wandering the streets of Philadelphia." Since then, hospitals have come to dominate the American medical landscape. Yet in recent decades, the rationale for concentrating so much care under one roof has diminished steadily. Many hospitals still exist in their current form largely because they are protected by regulation and favored by government payment policies, which effectively maintain the existing industrial structure, rather than encouraging innovation.

Between 1970 and 2006, annual Medicare payments to hospitals grew by roughly 3,800 percent, from \$5 billion to \$192 billion. Total annual hospital-care costs for all patients grew from \$28 billion to almost \$650 billion during that same period. Since 1975, hospitals' enormous revenue growth has occurred *despite* a 35 percent decline in the number of hospital beds, no meaningful increase in total admissions, and an almost 50 percent decline in the average length of stay. High-tech equipment has been dispersed to medical practices, recovery periods after major procedures have shrunk, and pharmaceutical therapies have grown in importance, yet over the past 40 years, hospitals have managed to retain the same share (roughly one-third) of our nation's health-care bill.

Hospitals have sought to use the laws and regulations originally designed to serve patients to preserve their business model. Their argument is the same one that's been made before by regulated railroads, electric utilities, airlines, Ma Bell, and banks: new competitors, they say, are using their cost advantages to skim off the best customers; without those customers, the incumbents will no longer be able to subsidize essential services that no one can profitably provide to the public.

Hospitals are indeed required to provide emergency care to any walk-in patient, and this obligation is a meaningful public service. But how do we know whether the charitable benefit from this requirement justifies the social cost of expensive hospital care and poor quality? We don't know. Our system of health-care law and regulation has so distorted the functioning of the market that it's impossible to measure the social costs and benefits of maintaining hospitals' prominence. And again, the distortions caused by a reluctance to pay directly for health care—in this case, emergency medicine for the poor—are in large part to blame.

Consider the oft-quoted "statistic" that emergency-room care is the most expensive form of treatment. Has anyone who believes this ever actually been to an emergency room? My sister is an emergency-medicine physician; unlike most other specialists, ER docs usually work on scheduled shifts and are paid fixed salaries that place them in the lower ranks of physician compensation. The doctors and other workers are hardly underemployed: typically, ERs are unbelievably crowded. They have access to the facilities and equipment of the entire hospital, but require very few dedicated resources of their own. They benefit from the group buying power of the entire institution. No expensive art decorates the walls, and the waiting rooms resemble train-station waiting areas. So what *exactly* makes an ER more expensive than other forms of treatment?

Perhaps it's the accounting. Since charity care, which is often performed in the ER, is one justification for hospitals' protected place in law and regulation, it's in hospitals' interest to shift costs from overhead and other parts of the hospital to the ER, so that the costs of charity care—the public service that hospitals are providing—will appear to be high. Hospitals certainly lose money on their ERs; after all, many of their customers pay nothing. But to argue that ERs are costly compared with other treatment options, hospitals need to claim expenses well beyond the marginal (or incremental) cost of serving ER patients.

In a recent IRS survey of almost 500 nonprofit hospitals, nearly 60 percent reported providing charity care equal to less than 5 percent of their total revenue, and about 20 percent reported providing less than 2 percent. Analyzing data from the American Hospital Directory, *The Wall Street Journal* found that the 50 largest nonprofit hospitals or hospital systems made a combined “net income” (that is, profit) of **\$4.27 billion in 2006**, nearly eight times their profits five years earlier.

How do we know whether the value of hospitals’ charitable services compensates for the roughly 100,000 deaths from hospital-borne disease, their poor standards of customer service, and their extraordinary diseconomies of both scale and scope? Might we be better off reforming hospitals, and allowing many of them to be eliminated by competition from specialty clinics? As a society, couldn’t we just pay directly for the services required by the poor? We don’t know how many hospitals would even survive if they were not so favored under the law; anyone who has lost a loved one to a preventable hospital death will wonder how many should.

YOU ARE NOT THE CUSTOMER

What amazed me most during five weeks in the ICU with my dad was the survival of paper and pen for medical instructions and histories. In that time, Dad was twice taken for surgical procedures intended for other patients (fortunately interrupted both times by our intervention). My dry cleaner uses a more elaborate system to track shirts than this hospital used to track treatment.

Not every hospital relies on paper-based orders and charts, but most still do. Why has adoption of clinical information technology been so slow? Companies invest in IT to reduce their costs, reduce mistakes (itself a form of cost-saving), and improve customer service. Better information technology would have improved my father’s experience in the ICU—and possibly his chances of survival.

But my father was not the customer; Medicare was. And although Medicare has experimented with new reimbursement approaches to drive better results, no centralized reimbursement system can be supple enough to address the many variables affecting the patient experience. Certainly, Medicare wasn’t paying for the quality of service during my dad’s hospital stay. And it wasn’t really paying for the quality of his care, either; indeed, because my dad got sepsis in the hospital, and had to spend weeks there before his death, the hospital was able to charge a lot more for his care than if it had successfully treated his pneumonia and sent him home in days.

Of course, one area of health-related IT has received substantial investment—billing. So much for the argument, often made, that privacy concerns or a lack of agreed-upon standards has prevented the development of clinical IT or electronic medical records; presumably, if lack of privacy or standards had hampered the digitization of health records, it also would have prevented the digitization of the accompanying bills. To meet the needs of the government bureaucracy and insurance companies, most providers now bill on standardized electronic forms. In case you wonder who a care provider’s real customer is, try reading one of these bills.

For that matter, try discussing prices with hospitals and other providers. Eight years ago, my wife needed an MRI, but we did not have health insurance. I called up several area hospitals, clinics, and doctors’ offices—all within about a one-mile radius—to find the best price. I was surprised to discover that prices quoted, for an identical service, varied widely, and that the lowest price was \$1,200. But what was truly astonishing was that several providers refused to quote any price. Only if I came in and actually ordered the MRI could we discuss price.

Several years later, when we were preparing for the birth of our second child, I requested the total cost of the delivery and related procedures from our hospital. The answer: the hospital discussed price only with uninsured patients. What about my co-pay? They would discuss my potential co-pay only if I were applying for financial assistance.

Keeping prices opaque is one way medical institutions seek to avoid competition and thereby keep prices up. And they get away with it in part because so few consumers pay directly for their own care—insurers, Medicare, and Medicaid are basically the whole game. But without transparency on prices—and the related data on measurable outcomes—efforts to give the consumer more control over health care have failed, and always will.

Here's a wonderful example of price opacity. Advocates for the uninsured complain that hospitals charge uninsured patients, on average, 2.5 times the amount charged to insured patients. Hospitals defend themselves by contending that they earn from uninsured patients only 25 percent of the amount they do from insured ones. *Both statements appear to be true!*

How is this possible? Well, hospitals bill according to their price lists, but provide large discounts to major insurers. Individual consumers, of course, don't benefit from these discounts, so they receive their bills at full list price (typically about 2.5 times the bill to an insured patient). Uninsured patients, however, pay according to how much of the bill the hospital believes they can afford (which, on average, amounts to 25 percent of the amount paid by an insured patient). Nonetheless, whatever discount a hospital gives to an uninsured patient is entirely at its discretion—and is typically negotiated only after the fact. Some uninsured patients have been driven into bankruptcy by hospital collections. American industry may offer no better example of pernicious "price discrimination," nor one that entails greater financial vulnerability for American families.

It's astonishingly difficult for consumers to find *any* health-care information that would enable them to make informed choices—based not just on price, but on quality of care or the rate of preventable medical errors. Here's one place where legal requirements might help. But only a few states require institutions to make this sort of information public in a usable form for consumers. So while every city has numerous guidebooks with reviews of schools, restaurants, and spas, the public is frequently deprived of the necessary data to choose hospitals and other providers.

THE STRANGE BEAST OF HEALTH-CARE TECHNOLOGY

One of the most widely held pieces of conventional wisdom about health care is that new technology is relentlessly driving up costs. Yet over the past 20 years, I've bought several generations of microwave ovens, personal computers, DVD players, GPS devices, mobile phones, and flat-screen TVs. I bank mostly at ATMs, check out my own goods at self-serve supermarket scanners, and attend company meetings by videoconference. Technology has transformed much of our daily lives, in almost all cases by adding quantity, speed, and quality while *lowering* costs. So why is health care different?

Well, for the most part, it isn't. Whether it's new drugs to control previously untreatable conditions, diagnostic equipment that enhances physician productivity, or minimally invasive techniques that speed patient recovery, technology-driven innovation has been transforming care at least as greatly as it has transformed the rest of our lives.

But most health-care technologies don't exist in the same world as other technologies. Recall the MRI my wife needed a few years ago: \$1,200 for 20 minutes' use of a then 20-year-old technology, requiring a little electricity and a little labor from a single technician and a radiologist. Why was the price so high? Most MRIs in this country are reimbursed by insurance or Medicare, and operate in the limited-competition, nontransparent world of insurance pricing. I don't even know the price of many of the diagnostic services I've needed over the years—usually I've just gone to whatever provider my physician recommended, without asking (my personal contribution to the moral-hazard economy).

By contrast, consider LASIK surgery. I still lack the (small amount of) courage required to get LASIK. But I've been considering it since it was introduced commercially in the 1990s. The surgery is seldom covered by insurance, and exists in the competitive economy typical of most other industries. So people who get LASIK surgery—or for that matter most cosmetic surgeries, dental procedures, or other mostly uninsured treatments—act like consumers. If you do an Internet

search today, you can find LASIK procedures quoted as low as \$499 per eye—a decline of roughly 80 percent since the procedure was introduced. You'll also find sites where doctors advertise their own higher-priced surgeries (which more typically cost about \$2,000 per eye) and warn against the dangers of discount LASIK. Many ads specify the quality of equipment being used and the performance record of the doctor, in addition to price. In other words, there's been an active, competitive market for LASIK surgery of the same sort we're used to seeing for most goods and services.

The history of LASIK fits well with the pattern of all capital-intensive services outside the health-insurance economy. If you're one of the first ophthalmologists in your community to perform the procedure, you can charge a high price. But once you've acquired the machine, the actual cost of performing a single procedure (the marginal cost) is relatively low. So, as additional ophthalmologists in the neighborhood invest in LASIK equipment, the first provider can meet new competition by cutting price. In a fully competitive marketplace, the procedure's price will tend toward that low marginal cost, and ophthalmologists looking to buy new machines will exert downward pressure on both equipment and procedure prices.

No business likes to compete solely on price, so most technology providers seek to add features and performance improvements to new generations of a machine—anything to keep their product from becoming a pure commodity. Their success depends on whether the consumers will pay enough for the new feature to justify its introduction. In most consumer industries, we can see this dynamic in action—observe how DVD players have moved in a few years from a high-priced luxury to a disposable commodity available at discount stores. DVD players have run out of new features for which customers will pay premium prices.

Perhaps MRIs have too. After a long run of high and stable prices, you can now find ads for discount MRIs. But because of the peculiar way we pay for health care, this downward price pressure on technology seems less vigorous. How well can insurance companies and government agencies judge the value of new features that tech suppliers introduce to keep prices up? Rather than blaming technology for rising costs, we must ask if moral hazard and a lack of discipline in national health-care spending allows health-care companies to avoid the forces that make nonmedical technology so competitive.

In 2002, the U.S. had almost six times as many CT scanners per capita as Germany and four times as many MRI machines as the U.K. Traditional reformers believe it is this rate of investment that has pushed up prices, rather than sustained high prices that have pushed up investment. As a result, many states now require hospitals to obtain a Certificate of Need before making a major equipment purchase. In its own twisted way, this makes sense: moral hazard, driven by insurance, for years allowed providers to create enough demand to keep new MRI machines humming at any price.

But Certificates of Need are just another Scotch-tape reform, an effort to maintain the current system by treating a symptom rather than the underlying disease. Technology is driving up the cost of health care for the same reason every other factor of care is driving up the cost—the absence of the forces that discipline and even drive down prices in the rest of our economy. Only in the bizarre parallel universe of health care could limiting supply be seen as a sensible approach to keeping prices *down*.

THE LIMITS OF “COMPREHENSIVE” HEALTH-CARE REFORM

A wasteful insurance system; distorted incentives; a bias toward treatment; moral hazard; hidden costs and a lack of transparency; curbed competition; service to the wrong customer. These are the problems at the foundation of our health-care system, resulting in a slow rot and requiring more and more money just to keep the system from collapsing.

How would the health-care reform that's now taking shape solve these core problems? The Obama administration and Congress are still working out the details, but it looks like this generation of “comprehensive” reform will not address the underlying issues, any more than previous efforts did. Instead it will put yet more patches on the walls of an edifice that is

fundamentally unsound—and then build that edifice higher.

A central feature of the reform plan is the expansion of comprehensive health insurance to most of the 46 million Americans who now lack private or public insurance. Whether this would be achieved entirely through the extension of private commercial insurance at government-subsidized rates, or through the creation of a “public option,” perhaps modeled on Medicare, is still being debated.

Regardless, the [administration has suggested a cost to taxpayers of \\$1 trillion to \\$1.5 trillion over 10 years](#). That, of course, will mean another \$1 trillion or more not spent on other things—environment, education, nutrition, recreation. And if the history of previous attempts to expand the health safety net are any guide, that estimate will prove low.

The reform plan will also feature a variety of centrally administered initiatives designed to reduce costs and improve quality. These will likely include a major government investment to promote digitization of patient health records, an effort to collect information on best clinical practices, and changes in the way providers are paid, to better reward quality and deter wasteful spending.

All of these initiatives have some theoretical appeal. And within the confines of the current system, all may do some good. But for the most part, they simply do not address the root causes of poor quality and runaway costs.

Consider information technology, for instance. Of course the health system could benefit from better use of IT. The Rand Corporation has estimated that the widespread use of electronic medical records would eventually yield annual savings of \$81 billion, while also improving care and reducing preventable deaths, and the White House estimates that creating and spreading the technology would cost just \$50 billion. But in what other industry would an investment with such a massive annual return not be funded by the industry itself? (And while \$50 billion may sound like a big investment, it’s only about 2 percent of the health-care industry’s annual revenues.)

Technology is effective only when it’s properly applied. Since most physicians and health-care companies haven’t adopted electronic medical records on their own, what makes us think they will appropriately use all this new IT? Most of the benefits of the technology (record portability, a reduction in costly and dangerous clinical errors) would likely accrue to patients, not providers. In a consumer-facing industry, this alone would drive companies to make the investments to stay competitive. But of course, we patients aren’t the real customers; government funding of electronic records wouldn’t change that.

I hope that whatever reform is finally enacted this fall works—preventing people from slipping through the cracks, raising the quality standard of the health-care industry, and delivering all this at acceptable cost. But looking at the big picture, I fear it won’t. So I think we should at least begin to debate and think about larger reforms, and a different direction—if not for this round of reform, then for the next one. Politics is, of course, the art of the possible. If our health-care crisis does not abate, the possibilities for reform may expand beyond their current, tight limits.

A WAY FORWARD

The most important single step we can take toward truly reforming our system is to move away from comprehensive health insurance as the single model for financing care. And a guiding principle of any reform should be to put the consumer, not the insurer or the government, at the center of the system. I believe if the government took on the goal of better supporting consumers—by bringing greater transparency and competition to the health-care industry, and by directly subsidizing those who can’t afford care—we’d find that consumers could buy much more of their care directly than we might initially think, and that over time we’d see better care and better service, at lower cost, as a result.

A more consumer-centered health-care system would not rely on a single form of financing for health-care purchases; it

would make use of different sorts of financing for different elements of care—with routine care funded largely out of our incomes; major, predictable expenses (including much end-of-life care) funded by savings and credit; and massive, unpredictable expenses funded by insurance.

For years, a number of reformers have advocated a more “consumer-driven” care system—a term coined by the Harvard Business School professor [Regina Herzlinger](#), who has written extensively on the subject. Many different steps could move us toward such a system. Here’s one approach that—although it may sound radical—makes sense to me.

First, we should replace our current web of employer- and government-based insurance with a single program of catastrophic insurance open to all Americans—indeed, all Americans should be required to buy it—with fixed premiums based solely on age. This program would be best run as a single national pool, without underwriting for specific risk factors, and would ultimately replace Medicare, Medicaid, and private insurance. All Americans would be insured against catastrophic illness, throughout their lives.

Proposals for true catastrophic insurance usually founder on the definition of *catastrophe*. So much of the amount we now spend is dedicated to problems that are considered catastrophic, the argument goes, that a separate catastrophic system is pointless. A typical catastrophic insurance policy today might cover any expenses above, say, \$2,000. That threshold is far too low; ultimately, a threshold of \$50,000 or more would be better. (Chronic conditions with expected annual costs above some lower threshold would also be covered.) We might consider other mechanisms to keep total costs down: the plan could be required to pay out no more in any year than its available premiums, for instance, with premium increases limited to the general rate of inflation. But the real key would be to restrict the coverage to true catastrophes—if this approach is to work, only a minority of us should ever be beneficiaries.

How would we pay for most of our health care? The same way we pay for everything else—out of our income and savings. Medicare itself is, in a sense, a form of forced savings, as is commercial insurance. In place of these programs and the premiums we now contribute to them, and along with catastrophic insurance, the government should create a new form of health savings account—a vehicle that has existed, though in imperfect form, since 2003. Every American should be required to maintain an HSA, and contribute a minimum percentage of post-tax income, subject to a floor and a cap in total dollar contributions. The income percentage required should rise over a working life, as wages and wealth typically do.

All noncatastrophic care should eventually be funded out of HSAs. But account-holders should be allowed to withdraw money for any purpose, without penalty, once the funds exceed a ceiling established for each age, and at death any remaining money should be disbursed through inheritance. Our current methods of health-care funding create a “use it or lose it” imperative. This new approach would ensure that families put aside funds for future expenses, but would not force them to spend the funds only on health care.

What about care that falls through the cracks—major expenses (an appendectomy, sports injury, or birth) that might exceed the current balance of someone’s HSA but are not catastrophic? These should be funded the same way we pay for most expensive purchases that confer long-term benefits: with credit. Americans should be able to borrow against their future contributions to their HSA to cover major health needs; the government could lend directly, or provide guidelines for private lending. Catastrophic coverage should apply with no deductible for young people, but as people age and save, they should pay a steadily increasing deductible from their HSA, unless the HSA has been exhausted. As a result, much end-of-life care would be paid through savings.

Anyone with whom I discuss this approach has the same question: How am I supposed to be able to afford health care in this system? Well, what if I gave you \$1.77 million? Recall, that’s how much an insured 22-year-old at my company could expect

to pay—and to have paid on his and his family’s behalf—over his lifetime, assuming health-care costs are tamed. Sure, most of that money doesn’t pass through your hands now. It’s hidden in company payments for premiums, or in Medicare taxes and premiums. But think about it: If you had access to those funds over your lifetime, wouldn’t you be able to afford your own care? And wouldn’t you consume health care differently if you and your family didn’t have to spend that money *only* on care?

For lower-income Americans who can’t fund all of their catastrophic premiums or minimum HSA contributions, the government should fill the gap—in some cases, providing all the funding. You don’t think we spend an absurd amount of money on health care? If we abolished Medicaid, we could spend the same money to make a roughly \$3,000 HSA contribution and a \$2,000 catastrophic-premium payment for 60 million Americans every year. That’s a \$12,000 annual HSA plus catastrophic coverage for a low-income family of four. Do we really believe most of them wouldn’t be better off?

Some experts worry that requiring people to pay directly for routine care would cause some to put off regular checkups. So here’s a solution: the government could provide vouchers to all Americans for a free checkup every two years. If everyone participated, the annual cost would be about \$30 billion—a small fraction of the government’s current spending on care.

Today, insurance covers almost all health-care expenditures. The few consumers who pay from their pockets are simply an afterthought for most providers. Imagine how things might change if more people were buying their health care the way they buy anything else. I’m certain that all the obfuscation over prices would vanish pretty quickly, and that we’d see an end to unreadable bills. And that physicians, who spend an enormous amount of time on insurance-related paperwork, would have more time for patients.

In fact, as a result of our fraying insurance system, you can already see some nascent features of a consumer-centered system. Since 2006, [Wal-Mart has offered \\$4 prescriptions](#) for a month’s supply of common generic medications. It has also been slowly rolling out retail clinics for routine care such as physicals, blood work, and treatment for common ailments like strep throat. Prices for each service are easily obtained; most are in the neighborhood of \$50 to \$80. Likewise, “concierge care,” or the “boutique” style of medical practice—in which physicians provide unlimited services and fast appointments in return for a fixed monthly or annual fee—is beginning to spread from the rich to the middle class. Qliance Medical Group, for instance, now operates clinics serving some 3,000 patients in the Seattle and Tacoma, Washington, areas, charging \$49 to \$79 a month for unlimited primary care, defined expansively.

It’s worth pausing over this last example. Many experts believe that the U.S. would get better health outcomes at lower cost if payment to providers were structured around the management of health or whole episodes of care, instead of through piecemeal fees. Medicare and private insurers have, to various degrees, moved toward (or at least experimented with) these sorts of payments, and are continuing to do so—but slowly, haltingly, and in the face of much obstruction by providers. But aren’t we likely to see just these sorts of payment mechanisms develop organically in a consumer-centered health-care system? For simplicity and predictability, many people will prefer to pay a fixed monthly or annual fee for primary or chronic care, and providers will move to serve that demand.

Likewise, what patient, when considering getting an artificial hip, would want to deal with a confusion of multiple bills from physicians, facilities, and physical therapists? Aren’t providers likely to organize themselves to provide a single price to the consumer for care and rehabilitation? And won’t that, in itself, put pressure on providers to work together as efficiently as possible, and to minimize the medical errors that would eat into their joint fee? I suspect we would see a rapid decline in the predominance of the fee-for-service model, making way for real innovation and choice in service plans and funding. And the payment system would not be set by fiat; it would remain responsive to treatment breakthroughs and changes in consumer demand.

Many consumers would be able to make many decisions, unaided, in such a system. But we'd also probably see the rise of health-care agents—paid by, and responsible to, the consumer—to help choose providers and to act as advocates during long and complex care episodes.

How else might the system change? Technological innovation—which is now almost completely insensitive to costs, and which often takes the form of slightly improved treatments for much higher prices—would begin to concern itself with value, not just quality. Many innovations might drive prices down, not up. Convenient, lower-cost specialty centers might proliferate. The need for unpaid indigent care would go away—everyone, recall, would have both catastrophic insurance and an HSA, funded entirely by the government when necessary—and with it much of the rationale for protecting hospitals against competition.

Of course, none of this would happen overnight. And the government has an essential role to play in arming consumers with good information. Congress should require maximum transparency on services, prices, and results (and some elements of the Obama administration's reform plan would move the industry in this direction). We should establish a more comprehensive system of quality inspection of all providers, and publish all the findings. Safety and efficacy must remain the cornerstone of government licensing, but regulatory bias should favor competition and prevent incumbents from using red tape to forestall competition.

Moving from the system we've got now to the one I've outlined would be complicated, and would take a long time. Most of us have been paying into an insurance system for years, expecting that our future health-care bills would be paid; we haven't been saving separately for these expenses. It would take a full generation to completely migrate from relying on Medicare to saving for late-life care; from Medicaid for the disadvantaged to catastrophic insurance and subsidized savings accounts. Such a transition would require the slow reduction of Medicare taxes, premiums, and benefit levels for those not yet eligible, and a corresponding slow ramp-up in HSAs. And the national catastrophic plan would need to start with much broader coverage and higher premiums than the ultimate goal, in order to fund the care needed today by our aging population. Nonetheless, the benefits of a consumer-centered approach—lower costs for better service—should have early and large dividends for all of us throughout the period of transition. The earlier we start, the less a transition will ultimately cost.

Many experts oppose the whole concept of a greater role for consumers in our health-care system. They worry that patients lack the necessary knowledge to be good consumers, that unscrupulous providers will take advantage of them, that they will overspend on low-benefit treatments and under-spend on high-benefit preventive care, and that such waste will leave some patients unable to afford highly beneficial care.

They are right, of course. Whatever replaces our current system will be flawed; that's the nature of health care and, indeed, of all human institutions. Our current system features all of these problems already—as does the one the Obama reforms would create. Because health care is so complex and because each individual has a unique health profile, no system can be perfect.

I believe my proposed approach passes two meaningful tests. It will do a better job than our current system of controlling prices, allocating resources, expanding access, and safeguarding quality. And it will do a better job than a more government-driven approach of harnessing medicine's dynamism to develop and spread the new knowledge, technologies, and techniques that improve the quality of life. We won't be perfect consumers, but we're more likely than large bureaucracies to encourage better medicine over time.

All of the health-care interest groups—hospitals, insurance companies, professional groups, pharmaceuticals, device manufacturers, even advocates for the poor—have a major stake in the current system. Overturning it would favor only the 300 million of us who use the system and—whether we realize it or not—pay for it. Until we start asking the type of questions

my father's death inspired me to ask, until we demand the same price and quality accountability in health care that we demand in everything else, each new health-care reform will cost us more and serve us less.

\$636,687.75

Ten days after my father's death, the hospital sent my mother a copy of the bill for his five-week stay: \$636,687.75. He was charged \$11,590 per night for his ICU room; \$7,407 per night for a semiprivate room before he was moved to the ICU; \$145,432 for drugs; \$41,696 for respiratory services. Even the most casual effort to compare these prices to marginal costs or to the costs of off-the-shelf components demonstrates the absurdity of these numbers, but why should my mother care? Her share of the bill was only \$992; the balance, undoubtedly at some huge discount, was paid by Medicare.

Wasn't this an extraordinary benefit, a windfall return on American citizenship? Or at least some small relief for a distraught widow?

Not really. You can feel grateful for the protection currently offered by Medicare (or by private insurance) only if you don't realize how much you truly spend to fund this system over your lifetime, and if you believe you're getting good care in return.

Would our health-care system be so outrageously expensive if each American family directly spent even half of that \$1.77 million that it will contribute to health insurance and Medicare over a lifetime, instead of entrusting care to massive government and private intermediaries? Like its predecessors, the Obama administration treats additional government funding as a solution to unaffordable health care, rather than its cause. The current reform will likely expand our government's already massive role in health-care decision-making—all just to continue the illusion that someone else is paying for our care.

But let's forget about money for a moment. Aren't we also likely to get worse care in any system where providers are more accountable to insurance companies and government agencies than to us?

Before we further remove ourselves as direct consumers of health care—with all of our beneficial influence on quality, service, and price—let me ask you to consider one more question. Imagine my father's hospital had to present the bill for his "care" not to a government bureaucracy, but to my grieving mother. Do you really believe that the hospital—forced to face the victim of its poor-quality service, forced to collect the bill from the real customer—wouldn't have figured out how to make its doctors wash their hands?

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