

As an American, I watch in astonishment when other countries debate whether to import anything resembling American health insurance companies into their health care systems. For decades, US per capita health care costs have been roughly double those of the rest of the industrialized world even though we leave one-sixth of our people uninsured. In the year 2002, the US spent \$5,267 per person on health care. Switzerland, which had the next most expensive system on the planet, spent \$3,446. The UK spent just \$2,160.

But despite the fact that the UK spends only 40 per cent as much as the US and still insures 100 percent of her people, and despite the fact that Americans are furious with their health insurance industry, the Labour Party has decided to transplant American healthcare corporations, including United Health Care and Kaiser Permanent, into the body of the National Health Service. I predict you will rue the day you let this happen.

In America these and other companies have operated as “health maintenance organizations” (HMOs), and have made a mess of the healthcare system. HMOs are insurance companies that influence doctors with two tools - financial incentives and “utilization review.” The financial incentives encourage doctors to deny services to their patients. Utilization review (UR) means an employee of the HMO vetoes or amends a decision made by a doctor and patient. To enhance the leverage of the financial-incentive and UR tools, HMOs often restrict the doctors patients can see in order to be able to funnel more patients to doctors on the staff of or on contract with the HMO. An HMO that insures, for example, 30 per cent of a clinic’s patients is far more likely to work its will over the clinic than an HMO that insures only 5 per cent of the clinic’s patients.

America's great experiment with HMOs began in the early 1970s, peaked in the mid-1990s, and crashed in the latter half of the 1990s. The experiment failed because HMO advocates diagnosed the cause of American health care inflation incorrectly, and, on the basis of that incorrect diagnosis, devised an awful solution. HMO advocates claimed inflation in American health care costs was due primarily to overuse of medical care caused by physicians who allegedly ordered unnecessary services in order to make themselves rich. HMO proponents argued that the solution to this alleged overuse was a new-fangled form of insurance company that controlled the decision-making of doctors.

By the mid-1980s, the vast majority of health insurance companies were using one or both of the two tools pioneered by HMOs. By 1985 the two tools were collectively called "managed care." Managed care was bound to fail for two reasons. First, it just isn't possible for bureaucrats who aren't doctors and who aren't in the examining room to make better clinical decisions than doctors and patients do. Second, the bureaucrats hired by the HMOs to manage doctors and hospitals raised insurance company costs, and the clerks that doctors and hospitals had to hire to deal with the new managed care bureaucrats raised provider costs as well.

By the late 1990s, it was apparent even to formerly enthusiastic proponents of managed care that the great American HMO experiment had failed. George Lundberg, who promoted managed care during his tenure as editor of the Journal of the American Medical Association, revealed his disgust for managed care in a 2001 interview with the Los Angeles Times. “Managed care is basically over,” he said.

“People hate it, and it's no longer controlling costs. Healthcare inflation is now back in the double digits. So if it's not saving money, then why should we have it? But like an unembalmed corpse decomposing, dismantling managed care is going to be very messy and very smelly, and take awhile.”

As it became clear even to the obtuse that managed care had failed, the insurance industry, with encouragement from Republicans, began to promote high-deductible policies as the solution to the US health care crisis. They called these high-deductible policies “medical savings accounts” in the 1990s, and then switched to the phrase “health savings accounts” (HSAs) in 2003. These insurance policies have annual deductibles on the order of \$2,000 for individuals and \$5,000 for families.

Repeating the mistakes of HMO proponents before them, HSA proponents have made the wrong diagnosis. Like HMO advocates, they claim overuse of medical services is the main problem. Unlike HMO advocates, they claim the overuse is caused by whiny, “overinsured” patients, not greedy doctors. Patients, we are told now, demand medical services they don't need just because they have insurance with “low” deductibles (the deductible in a typical managed care policy these days is \$500 for family coverage).

The argument that Americans overuse medical care is not a lie, but it is a half-truth, or better yet, a quarter-truth. The overuse argument ignores two facts: Underuse of medical care in the US is rampant, even among the insured; and the insurance and medical industries are dreadfully wasteful.

The latest data on overuse and underuse show that underuse occurs four times more often than overuse. For example, half of all insured Americans with high blood pressure are not being treated for it. For another example, a quarter of insured Americans who have been told their angiogram indicates they need bypass surgery or balloon angioplasty have neither procedure done. The truth is the average American underuses health care, and managed care and high deductibles will only make this problem worse.

The other fact concealed by HSA advocates is that the supply side of the US health care system - the insurance and medical industries - waste hundreds of billions of dollars on excessive administrative costs, redundant purchases of equipment such as MRIs, overcharging by specialists and drug companies, and fraud. It is this supply-side waste that America needs to address, and we cannot address it by exposing patients to \$5,000 and hoping they will refrain from self-rationing and will arm-wrestle with their hospital or their drug manufacturer to bring their prices down.

America has just emerged from one dumb experiment - the managed care experiment - imposed upon us by our powerful health insurance industry. It now appears likely we will stumble into another stupid experiment - HSAs - brought to us by the US health insurance industry. But this experiment too will fail, and fail rather quickly. At that point, America may finally turn to single-payer system, or components of a single-payer system, that address the real cause of our horrendous healthcare costs - waste in the insurance and medical industries.

Kip Sullivan sits on the steering committee of the Minnesota Universal Health Care Coalition. He is the author of *The Health Care Mess*, published by AuthorHouse, February 2006.