

March 8, 1993

WHY GLOBAL BUDGETS AND PRICE CONTROLS WILL NOT CURB HEALTH COSTS

It is our pleasure, therefore, that those prices, which the concise items in the following list indicate, be held in attention throughout our whole domain, in such a way that all men understand that freedom to exceed them is removed.

-Roman Emperor Gaius Aurelius Valerius Diocletian
(Edict of 301 A.D. fixing maximum prices and wages)

$$P(t) = \sum_i (P_i(t) \times (\frac{R_i}{\sum_j R_j}))$$

Carter Administration Council on Wage and Price Stability, *Fact Book: Wage and Price Standards*, October 31, 1978. (How to figure company-wide average price in any quarter.)

$$\text{Payment} = (\{RVU_{ws} \times GPC_{lwa}\} + \{RVU_{pes} \times GPC_{lpea}\} + \{RVU_{ms} \times GPC_{lma}\}) \times CF$$

Federal Register, "Medicare Program; Fee Schedule for Physicians; Proposed Rule," June 5, 1991. (How the federal government now calculates physician fees under Medicare.)

Those who cannot remember the past are condemned to repeat it.

George Santayana
(1863-1952)

INTRODUCTION

Members of Congress should recall the firestorm of protest that followed the imposition of higher taxes on the elderly in the Medicare Catastrophic Act of 1988 to gauge the likely public reaction to a policy that would explicitly deny medical services to Americans, or reduce the quantity or quality of those services. For that would be the result of imposing government-dictated national budgets, known as “global budgets,” and price controls on the United States health system, moves now being contemplated by the Clinton Administration and many in Congress.

Some lawmakers believe government-imposed national health budgets would lead to a more careful allocation of medical resources, reducing costs and improving efficiency. But the real effect has been bluntly but accurately summed up by Stanford University Professor Alain Enthoven as more similar to “bombing from 35,000 feet, where you don’t see the faces of the people you kill.”¹

For over four thousand years, rulers and peoples of every time, place, and culture have attempted to repeal the laws of economics by legislating price controls. Sometimes price controls were imposed on entire economies, while at other times only on certain goods or services such as food, housing, or medical care. Yet in every instance, the imposition of price controls produced harmful results. In some cases, the human suffering caused by a price control experiment was mild or short-lived. Lawmakers need look no further than the 1970s to see the failure of President Nixon’s wage and price controls and the gas lines created by price controls on oil. In other cases, price controls inflicted such colossal damage on the economy that they profoundly changed the course of history.²

Price controls would not work in health care because they attack the symptoms of runaway costs, not the cause. Medical costs today are soaring because consumers are largely insulated from them by the illusion that employers pay for their health insurance coverage, and because the tax system discourages consumers from seeking good value for money in health care. This situation leads to calls for price controls on visible out-of-pocket medical costs, such as outpatient pharmaceuticals, and on insurance premiums, while more rapidly rising medical costs go unnoticed by most Americans who do not pay them directly.

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- 1 Enthoven, one of the architects of the managed competition approach to health care reform, made the comment during a recent conference on health care reform, as reported in *Health News Daily*, January 11, 1993, p. 2.
 - 2 Having completely undermined their national economies through long-standing price controls, when Soviet and East European communist leaders attempted reform, the entire social and economic structure quickly collapsed beneath them. Yet the contribution of price controls to the collapse of communism, and the resulting dramatic shift in the course of history, is not unprecedented. For example, the decline and collapse of ancient Egyptian civilization in the third century B.C. also resulted in large measure from the prolonged imposition of price controls. For a fascinating, detailed historical examination of price controls, see *Forty Centuries of Wage and Price Controls: How Not To Fight Inflation*, by Robert L. Schuettinger and Eamonn F. Butler, The Heritage Foundation, 1979. Some of the most notable historical examples of price control regimes include the Babylonian experiment in the 21st century B.C., ordained by the Code of Hammurabi, the Roman emperor Diocletian’s comprehensive wage and price control regime (301 A.D.), and the experience of Nazi Germany, 1933 to 1945.

A fixed "global" budget also would attack the symptom, not the cause. Further, the international experience shows that enforcing a tight budget not only produces unwelcome results and inefficiency, but also would require the kind of tough rationing decisions few lawmakers seem prepared to make.

Price controls not only do not work, but international and U.S. experience shows they produce severe side effects that would be unacceptable to the vast majority of Americans, including:

- ◆ **Price controls lead to shortages of the goods or services subject to control which, in turn, results in waiting lists for the limited supply.**

Example: At any given time, approximately 1 million Britons and 250,000 Canadians are waiting months or even years for needed tests and operations because their governments limit the funding of hospitals through global budgets.

- ◆ **Price controls benefit well-connected and richer consumers at the expense of others.**

Example: When Robert Bourassa, the Premier of Quebec, needed treatment for potentially fatal skin cancer, he crossed into the U.S. and obtained treatment at his own expense at the National Cancer Institute in Bethesda, Maryland.

- ◆ **Price controls encourage black markets and bribery.**

Example: In Japan, patients seeking quicker and better quality care can expect to pay bribes of between \$1,000 and \$3,000 to obtain treatment from a senior specialist in a university hospital.

Congress should resist the idea of imposing price controls on the health care industry as a solution to the soaring cost of medical care. Inevitably, such a remedy will end in failure or create more problems than it solves. Lawmakers should carefully examine the substantial, accumulated evidence of historical experience with the failures of price controls. If they are as wise as their predecessors in the Continental Congress, who passed a resolution against price controls in 1778, today's Congressmen will also conclude that price controls are a dangerous mistake.³ If they do not, they will yet again condemn America to repeat the errors of the past.

3 *Ibid.*, pp 41-42. After Washington's army nearly starved to death at Valley Forge during the winter of 1777-1778, largely as a result of Pennsylvania's price controls on goods needed by the military, the Continental Congress adopted in June of 1778 a resolution which read in part:

"Whereas...it hath been found by experience that limitations upon the prices of commodities are not only ineffectual for the purposes proposed, but likewise productive of very evil consequences to the great detriment of the public service and grievous oppression of individuals...resolved, that it be recommended to the several states to repeal or suspend all laws or resolutions within the said states respectively limiting, regulating or restraining the Price of any Article, Manufacture or Commodity."

WHAT ARE PRICE CONTROLS?

Price controls are government restrictions on prices. Usually these take the form of ceilings that stipulate the legal maximum price a producer can charge for a particular good or service. Governments impose such controls normally in an attempt to stop a rapid rise in the cost of a good or service during a shortage, in an attempt to benefit a favored constituency, or in an attempt to hold down a general increase in inflation. Usually controls are applied to specific goods and services such as on oil during the Arab oil embargo of 1973-1974. But price controls can also be imposed on an economy-wide basis, as they were in 1971 during the Nixon Administration, in an attempt to moderate general inflation.

Government officials often cling to dubious economic theories to justify price controls. But in reality, governments impose price controls either to compensate for the adverse consequences of their own policies or in response to pressure from a segment of the population that is angry about the rising cost of a good or service.

Economy-wide price controls, for instance, are an attempt to compensate for the harmful effects of the government's own inflationary monetary policy.⁴ As such, they have at best a temporary impact—if any—on general inflation. Only dealing with the root monetary policy causes of inflation ever produces a real impact.

In cases where governments impose price controls only on certain goods or services, the motive normally is to provide benefits to a favored constituency.⁵

But selective price controls usually end up harming the very constituency the politicians are trying to help. For example, long-standing rent controls destroy incentives to build and maintain low-income housing, resulting in less housing for the poor—the very ones who were supposed to benefit from the controls.⁶

In the case of health care, calls for price controls are seen as fulfilling both purposes. Most policy makers who favor health care price controls view them as a way to curb rapid medical inflation. But most of the blame for that same inflation can be traced directly to previous government health care policies that they support or maintain. Health care price controls also are attractive to Members of Congress because they provide a benefit (cheaper medical care) to a favored constituency (health care consumers) at the expense of less favored constituencies (doctors, hospitals, pharmaceutical manufacturers, and insurance companies). This is why some Members of Congress are so quick to blame the health care industry for escalating medi-

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- 4 History contains many examples of economy-wide inflation sparked by a government devaluing the currency by printing or minting too much money too quickly. Usually governments turn to such inflationary practices as an alternative to raising taxes to finance large expenditures on wars, political constituencies, public works, or the rulers themselves. The Roman Empire, for example, spent lavishly on all these categories — spending which it tried to finance by repeatedly debasing the Imperial coinage. Diocletian and other Roman Emperors then attempted periodically to tame the resulting inflation by imposing prices controls, all to no avail.
 - 5 For example, the governments of some Third World countries impose price controls on farmers to win favor among the urban population by providing them cheap food. Ironically, the effect of such a policy is to reduce farm income and drive farmers off the land and into poverty in the cities—where at least they can get cheap food! Of course, fewer farmers means less food and thus increasing discontent among the now growing urban population.
 - 6 For a good analysis of the adverse effects of rent controls on housing markets and the poor, see William Tucker, *the Excluded Americans: Homelessness and Housing Policies* (Washington, D.C.: Regnery Gateway, 1990).

cal costs, when in fact it is largely government laws, regulations, and policies that are responsible.

WHY THE PRICE OF MEDICAL CARE IS RISING

To understand why health care price controls will not work, and are likely to make matters worse, it is necessary to understand why the cost of medical care is rising in the first place.

Under normal market conditions, when supply exceeds demand, prices drop until equilibrium is restored. Economists call the price at which supply and demand are in balance, or equilibrium, the “market clearing price.” Conversely, when demand exceeds supply, the opposite occurs. Prices rise, stimulating producers to meet the demand. Once supply and demand are matched, prices stabilize.

Some analysts note that this fundamental law of economics does not seem to apply to the health care market. They observe that in health care, supply, demand, and price are all increasing. This leads some policy makers to conclude that health care markets do not function according to the normal laws of supply and demand. Following this logic, they argue that the only way to prevent health care costs from escalating is by restraining demand, supply, and prices through government regulation.

THE “FREE GOOD” ILLUSION

Policy makers favoring such regulation recognize that consumer demand for health care services is politically and technically the most difficult element of the equation to regulate. Therefore, these policy makers are more inclined to advocate imposing controls on medical prices and on the supply of health care personnel, facilities, and technology. The idea is to simply, and forcibly, ratchet down the prices consumers pay and—if necessary to keep total costs down—the supply of services.

What is invariably missing from this analysis, however, is an accurate understanding of why health care markets seem to behave differently from other markets. The real reason is not some “market failure,” but rather the huge distortions in health care financing incentives created by government policy. Having misdiagnosed the underlying cause of the problem, policy makers favoring price regulation therefore propose remedies which only will make the problem worse.

Rising American health care prices are not the result of free market forces. The reason: there is no “free market” in health care. In a normal market, consumers would buy medical care and health insurance directly and consider the relative costs and benefits in making their purchases, as they do, say, in buying automobiles or houses. In other words, consumers would seek the best value for money in medical care and health insurance. Health care providers and insurers would then compete to satisfy consumer demand by adjusting the price and quality of their goods and services to provide consumers with the best value for their money. Government’s role would largely be limited to providing the disadvantaged with subsidies to help them buy needed medical care and health insurance at market prices.

The problem is that health care markets are dysfunctional, both in the U.S. and abroad, because they have been disrupted by unwise government policies. The biggest disruption occurs when governments make medical services “free,” or artificially inexpensive, to consumers at the point of service. This policy generally characterizes national health insurance systems. In

Britain, for example, this is accomplished by the government operating a single, nationalized system of health insurance which pays health care providers directly. In Canada, most of the funding and administration is carried out at the local (provincial) level, under uniform guidelines established by the national government. In still other cases, such as Germany, the government compels citizens to purchase health insurance from regulated quasi-private plans.

What these systems have in common is that they all divorce the payment for health care (taxes or contributions) from the consumption of medical services. This leaves consumers with little or no basis on which to compare the quantity, quality, cost, or value of the services they obtain. Consequently, consumers view health care as a “free good” and have a natural incentive to demand more of it. At the same time, providers are freed from the economic discipline imposed by consumers seeking the best value for money in a normal market. Hence, providers have every incentive to offer an ever-increasing quantity of goods and services, of ever-increasing sophistication, at ever-increasing prices. Invariably that leaves government facing high demand for “free” services and overstretched budgets trying to accommodate the real cost of care.

The U.S. government has also adopted these mistaken policies. Today, 44 percent of all U.S. health care expenditures are directly paid for by government programs, and delivered to the public free of charge or at artificially low prices. They include: the federal Medicare program for the elderly, health care services for veterans through the Department of Veterans Affairs and the joint federal/state Medicaid program for the poor, as well as a number of smaller federal and state health programs. All these programs are subject to heavy demand and severe budget problems.

HOW TAX POLICY UNDERMINES THE HEALTH MARKET

In much of the rest of the U.S. health care system the market is distorted in another way. This is the private health care sector serving most working Americans. In this sector, medical care is paid for mainly by widespread, tax-supported, employer-sponsored health insurance for workers and their dependents. Workers often have little or no control over the cost or coverage of their employer-sponsored insurance. And even though such benefits are part of a worker’s compensation package, employees tend to view their insurance and the medical care it funds as paid for by their employer. Consequently, they have little direct incentive to consider the relative prices and benefits of medical treatments—something they do every day when buying other goods and services in the rest of the economy. Furthermore, federal tax policy provides workers with substantial tax relief on the money effectively taken from their wages by employers to pay for employer-sponsored insurance. But the government gives little or no tax relief for health insurance purchased outside the work place or for medical care paid for other than through employer-sponsored insurance. As a result of these tax policies, workers have few realistic alternatives to employer-sponsored plans, which effectively resemble miniature national health insurance systems. Thus consumers are largely insulated from the costs of the medical goods and services they consume, while doctors, hospitals, and insurers are largely insulated from normal consumer pressure on providers to boost quality while trimming costs and prices.⁷ It is this “breakdown” in the market, due to government policy, that triggers demands to control medical care prices directly.

7 For a more complete explanation of perverse incentives in the health care system see Stuart M. Butler, "A Policy

Ultimate Irony. Perhaps the ultimate irony is that these perverse incentives, which now lead to demands for price controls, themselves stem from government price controls imposed fifty years ago. When the federal government imposed comprehensive wage and price controls during World War II, employers responded by offering workers increased compensation in the form of non-cash benefits, such as health insurance, to evade wage controls and attract scarce labor. These benefits were further encouraged because the federal government did not tax the value of those non-cash benefits as income to the workers. Following the war, the controls were removed but the health benefits and tax breaks remained.

Thus was born, not by any grand design but rather as a side effect of price controls, America's unique system of heavily tax-favored, employer-sponsored health insurance. Half a century later, the perverse incentives for both consumers and providers inherent in this system continue to generate escalating health care costs and declining access to care.

WHY PHARMACEUTICALS ARE TARGET NUMBER ONE

Another irony is that one sector of the U.S. health care market less distorted by government health care financing policies, and therefore functioning more like a normal market, is also a sector that is a prime target for price controllers. That sector is outpatient prescription drugs. Medicare does not cover outpatient pharmaceuticals, and most employer-sponsored insurance plans either do not cover them or cover only part of their cost. Thus, Americans are more aware of the cost of pharmaceuticals, and so are easily led to believe that increasing prescription drug prices are a leading cause of health care cost escalation. In fact, the opposite is true.

Outpatient prescription drugs account for only 8.3 percent of total U.S. health spending. Furthermore, the share of national health spending devoted to pharmaceuticals in eight developed countries

Greece	26.3% (EC)
Germany	20.7 (EC, G7)
Spain	18.8 (EC)
Japan	18.4 (G7)
Portugal	18.2 (EC)
Italy	18.2 (EC, G7)
Belgium	17.4 (EC)
France	16.7 (EC, G7)
Luxembourg	15.5 (EC)
New Zealand	14.3
Iceland	12.9
Switzerland	12.3
Canada	11.6 (G7)
Austria	11.6
Britain	11.3 (EC, G7)
Ireland	11.2 (EC)
Netherlands	9.6 (EC)
Finland	9.5
Denmark	9.3 (EC)
United States	8.3 (G7)
Australia	8.3
Sweden	6.7
Norway	5.3

Source: "OECD Health Systems: Facts and Trends." OECD, forthcoming; and OECD Health Data, 1991, as reported in: "Health Care Systems in Twenty-Four Countries." Schieber, Poullier and Greenwald, *Health Affairs*, Fall, 1991.

Maker's Guide to the Health Care Crisis, Part I: The Debate Over Reform," Heritage Foundation *Talking Points*, February 12, 1992, and Edmund F. Haislmaier, "Why America's Health System Is in Trouble," in Stuart M. Butler and Edmund F. Haislmaier, eds., *A National Health System for America* (Washington, D.C.: The Heritage Foundation, 1989).

is more than twice the U.S. figure. Indeed, the U.S. percentage is the third lowest among 23 developed nations. Only Sweden and Norway spend proportionately less, and Australia spends the same share as the U.S. Ironically, Japan, Canada, and eleven of the twelve nations of the European Community (EC) all have some type of pharmaceutical price controls, yet spend proportionately more than the U.S. on drugs. In the one EC country without price controls, Denmark, spending on pharmaceuticals accounts for only 9.3 percent of national health spending—a share that is lower than any of the other eleven EC nations. Indeed, among the 23 developed nations only the U.S., Australia, Sweden, and Norway spend proportionately less on pharmaceuticals than Denmark. Even when drug spending is measured on an annual, per-capita basis (adjusted for currency purchasing power differences), the U.S., at \$182 per person, falls below the \$218 average for the 21

industrialized nations for which data are available, and well below some other major nations. For example, the U.S. spends less on drugs not only in percentage terms but also in per-capita terms than any of the other six nations which comprise the “Group of Seven” (G7) with the world’s biggest economies.

But the key political fact is that Americans pay for most prescription drugs out-of-pocket. Thus drug treatment for an ailment may be far less expensive than surgery, but cost much more as far as the patient concerned. For example, it may cost a patient \$500 a year in drugs to treat an ulcer, while ulcer surgery can cost \$7,000 or more (with far more risk to the patient). Similarly, a \$1,000 a year drug treatment for heart disease compares quite favorable to the alternative of \$30,000 or more for heart surgery. The problem, of course, is that because of the peculiarities of the America’s health care financing system, the choice to the patient is between paying a great deal out-of-pocket with after-tax dollars for a drug therapy, or paying very little directly for much more expensive surgery covered by their tax-free employer-provided insurance or a government program. Thus while patients may still choose the drug treatment because it is more effective or less risky, they are likely to complain loudly about its high cost (to them, directly) and blame the drug manufacturer for rising health care costs, when in fact the opposite is the case.

Per Capita Spending on Pharmaceuticals in Twenty-One OECD Countries, 1988

	U.S. Dollars*
France	\$492 (EC, G7)
Italy	349 (EC, G7)
Japan	332 (G7)
Luxembourg	325 (EC)
Germany	321 (EC, G7)
Belgium	304 (EC)
New Zealand	242
Spain	204 (EC)
Britain	201 (EC, G7)
Sweden	189
Australia	187
Canada	187 (G7)
Greece	187 (EC)
United States	182 (G7)
Finland	158
Austria	152
Denmark	140 (EC)
Netherlands	134 (EC)
Norway	106
Ireland	96 (EC)
Portugal	88 (EC)

* Calculated Using OECD Pharmaceutical Purchasing Power Parities.

Source: "OECD Health Systems: Facts and Trends," OECD, forthcoming; and OECD Health Data, 1991, as reported in: "Health Care Systems in Twenty-Four Countries," Schieber, Poullier and Greenwald, *Health Affairs*, Fall, 1991.

THE UNINTENDED SIDE EFFECTS OF PRICE CONTROLS

Because the problems of today's U.S. health care system result from policies that distort the health care market and introduce perverse incentives for consumers and providers, trying to suppress costs with price controls only tackles the symptoms, not the root cause. Like clamping down the lid of a pot of boiling water in an effort to stop it from boiling—rather than turning down the heat—price controls ultimately are ineffective and often produce even greater harm.⁸

Price controls inevitably lead to serious side effects that compound the original problems they were intended to solve. This has been the case in every part of the economy in which they have been applied, in the U.S. or in other countries.

Some Members of Congress and officials in the Clinton Administration want price controls imposed on the health care system, with the aim of keeping total U.S. health spending within a national—or “global”—budget. These policy makers would be wise to examine the side effects that accompany price controls in the economy. As a later section of this *Backgrounder* shows, health care is not exempt from these effects. Indeed, if price controls were to be imposed on the U.S. health care system, not only would they fail, but they would undermine seriously the quality and availability of medical care.

Among the side effects generally associated with price controls:

Side Effect #1: Price ceilings result in shortages of the goods or services subject to control.

History shows that shortages occur after government mandates lower prices. Perhaps the clearest and most frequent examples found throughout history are the food shortages which quickly follow the imposition of price controls on farm products. Unable to obtain a reasonable price for their goods, farmers simply withhold their existing produce from the market and cut future production. The same is true of other commodities. For example, price controls on oil and natural gas during the 1970s led producers to cut production, resulting in an energy shortage or “crisis.” As later sections of this study will show, when the controlled price of a medical service is below the market clearing price, patients demand more than doctors and hospitals are willing or able to supply.

⁸ A classic example of price controls making a bad situation much worse occurred in 1584-85, when Spanish forces under the Duke of Parma besieged the port city of Antwerp on land and gradually blockaded it from the sea as well. As food became scarce, the city fathers imposed price controls. While food was plentiful elsewhere, and merchants could have delivered vast quantities of supplies before the Spanish tightened their blockade, relief never came. The reason: Antwerp's price controls meant that merchants would get only the same price for their goods in Antwerp as they would get for selling them elsewhere at a much lower cost and risk. Naturally, the merchants sold elsewhere. At the same time, the artificially low prices set by the city government discouraged the citizens from limiting their consumption of scarce foodstuffs. The result: The population continued to eat heartily as if there was no shortage until the food ran out and they were forced to surrender. In the words of one historian, “the city, by its own stupidity, blockaded itself, far more effectively than the Duke of Parma could have done.” Schuettinger and Butler, *op. cit.*, pp. 33.

Side Effect #2: Price ceilings lead to reductions in the quality of the goods or services subject to control.

Since imposing a cap on the price of a service does not change the cost structure of providers, one common side effect of price controls is that providers cut quality, and hence cost, to maintain their income. This is a common response to price controls by manufacturing industries, and, for example, was a widespread result of price controls in the U.S. and Canada during World War II.⁹

The deterioration of rental housing subject to rent control is also a classic example of this phenomenon.¹⁰ The reason is that when landlords are prohibited from charging a true market price for their units, the only way to keep from losing money under rent controls is to reduce their costs. One of the few ways to reduce housing costs is to lower the amount of money spent on upkeep and maintenance. The response of tenants, of course, is to approve of low rental prices while condemning landlords for cutting maintenance.

As indicated later, the same phenomenon occurs in medical care. In countries with a price-controlled health system, such as Britain, the system remains popular despite offering poor quality service. Typically, citizens express the view that “the care may not be great, but at least it’s free,” and complain that not enough is spent on the system.

Side Effect #3: Price ceilings divert economic activity and investment from heavily controlled sectors into less controlled, or uncontrolled, sectors.

Price controls on oil and natural gas dramatically reduced the amount of money spent searching for new energy sources. The money did not disappear; it was invested in other areas of the economy. Similarly, as later sections of this *Backgrounder* will show, government-imposed price controls prevent doctors, hospitals, research organizations, and pharmaceutical companies from realizing a competitive return on certain types of investments. That distorts investment, leading to medical investments determined by bureaucratic regulation rather than potential value to society.

Side Effect #4: Price controls benefit well-connected and richer consumers at the expense of others.

When prices are controlled, those with good contacts or plenty of money receive a larger slice of a smaller pie. When gasoline price controls were in effect, friends of the gas station owner received a full tank despite the shortages. In rent-controlled New York, the rich simply pay “under the table” to obtain an apartment, while the less affluent wait or move into shoddy buildings.

The same holds true of health care. Canadian and British politicians—and their friends—receive good care, as do the affluent. The others have to compete for what is left.¹¹

⁹ *Ibid.*, pp. 81-84.

¹⁰ *Ibid.*, pp. 85-90.

¹¹ The wealthy and well-connected can also go elsewhere to obtain medical care. For example, in 1990 when Robert

Side Effect #5: Price controls encourage black markets.

A typical consequence of price controls is the evolution of black markets for controlled goods and services. Many buyers and sellers will simply make mutually beneficial transactions regardless of legal prohibitions. The back streets of price-controlled Eastern Europe thrived for decades with sales of black market goods.

Black market prices are almost always above true market prices, since sellers incur greater costs and risks in producing the product and finding customers. This would especially be true of medical services, where the demand is intense for cures or treatments to preserve life or increase the quality of life. Moreover, doctors prepared to circumvent the law would want to be compensated for their added costs and risks.

Side Effect #6: The longer price controls are in effect, the more serious the shortages of goods and services become and the more painful the adjustment process back to market prices.

Long-term imposition of price controls causes deep distortions in an economy. Much of the problem today in former communist nations is in making the transition from controlled to market prices. One reason policy makers often give for not removing long-standing price controls is that removing the controls will cause prices to soar immediately, while it will take time for supply to grow to meet pent-up demand and bring prices down again. Consequently, any period of adjustment following decontrol will have high transitional costs, leading to public anger, which politicians fear. This is exactly the situation found today in the former communist countries of Eastern Europe. But the alternative of continued controls would only perpetuate a failed system. The real lesson is that price controls should be avoided in the first place.

Side Effect #7: Price controls lead to costly and unpopular methods of allocating goods and services, such as queuing, rationing, and bribes.

Since price controls create shortages, there has to be an alternative way of allocating the quantity of the product being supplied among consumers. Unfortunately there are no good replacements for market prices. One traditional method is simply forcing citizens to wait in line. But queuing, whether for bread in the old Soviet Union or gas lines in America during the 1970s, is widely recognized as a waste of human resources. Every man-hour spent waiting in a line is time unavailable for more productive or enjoyable activities.

Explicit rationing is another common response to price controls. Rationing eliminates lines by giving consumers a legal claim to a set amount of the controlled good or service. In theory, the amount of claims distributed matches the limited quantity which will be produced at the control price. Rationing, however, is beset by many flaws, including the inevitable inability of government planners to judge what level of output will occur at any given fixed price. Even

Bourassa, the Premier of Quebec, needed treatment for melanoma, he obtained it at his own expense in the U.S. See Nancy Wood, "Missing, But Not Forgotten," *McLean's*, December 10, 1990, p. 14.

so, the government has to set forth a regulatory standard as to who will, or will not, get the claims. In the case of health care, the State of Oregon in 1992 proposed precisely that: setting up a list of the medical treatments it will and will not fund in its Medicaid program—thus effectively determining who would and who would not be eligible for treatment. Waiting lists, of course, characterize the national health insurance systems of Great Britain, Canada, and Sweden, among others.

Side Effect #8: Price controls reduce the penalties for discrimination by sellers.

In a free market, sellers who try to favor one group and discriminate against another penalize themselves by avoiding possible business. A landlord who does not rent to blacks, for instance, or a car dealer who ignores female potential customers will pay a price in lost income. But with heavy demand and shortages of supply induced by price controls, discrimination imposes no costs on the seller.

In the health care field, this problem becomes acute. If a doctor harbors certain prejudices, say, against AIDS patients or the poor, then the doctor can choose not to supply the same level of limited services to those he or she dislikes. Since shortages created by price controls mean the doctor is assured of being able to find enough patients to justify the maximum funding he or she is allocated by the government, there is no loss of income to punish discriminatory behavior. The government's likely response: more laws, more regulations, and more officials to enforce them.

Side Effect #9: Price controls reward those sellers who "game" the system, and penalize those who do not.

Any seller willing to evade price controls, such as by offering goods and services under the table for a premium, or by offering only the goods and services that provide the best return, can maintain or even increase his income under price controls. Those sellers who obey the rules strictly, by contrast, invariably see their incomes fall.

The same is true in medical care. When controls are placed on fees for certain procedures, as they are in Medicare and in many other countries, doctors who simply increase their volume by providing unnecessary tests and treatments maintain their income. Those doctors who continue to practice as they did before controls—doing only what is medically necessary—see their incomes fall.

THE DISMAL RECORD OF GLOBAL BUDGETS FOR HEALTH CARE

Despite the sorry history of price controls, President Bill Clinton, along with many congressional liberals, advocates extensive federal price controls in health care. Clinton has proposed a regime of price controls within government-imposed "global budgets" for all U.S. health spending, both public and private.

The claim is that this policy would directly attack escalating health care costs by setting a fixed limit on total health spending, and then use various price controls to keep spending within the official budget. Proposals of this kind usually would establish several layers of fixed budgets, with a national budget divided into state and local budgets, and ultimately into fixed budgets imposed on individual hospitals, clinics, and other health care facilities. Some proposals also call for separate fixed budgets for pharmaceuticals and medical equipment.

Global Budgets in Britain and Canada

The British government has operated its National Health Service, (NHS) on the principle of fixed budgets and price controls for over four decades. But recent British reforms have lifted these restrictions on some doctors and hospitals in an effort to make the system more responsive to patients.

Global budgets can, if rigorously enforced, constrain health care spending simply by denying funds to the medical industry. The problem is that they do nothing to restrain consumer demand—since patients view medical care as a free good, resulting in virtually unlimited consumer demand. The result is the classic first effect of price controls: the creation of shortages (*Side Effect #1*). These shortages are expressed primarily in the form of waiting lists for medical care (*Side Effect #7*). According to official government figures, almost 1 million Britons (the equivalent of 5 million Americans) are on a waiting lists for medical care at any given time.¹² Independent experts estimate that the real figure may be as much 200,000 greater than the official figure.

Such experiences are not unique to Britain. For example, the fixed-budget Swedish health system also experiences persistent waiting lists (*Side Effect #7*). A recent independent survey estimates that 250,000 Canadians (the equivalent of 2.5 million Americans) at any given time are kept waiting for medical care in a system that is frequently touted by some Members of Congress as a model for the U.S. to emulate.¹³ In these and other systems, it is not uncommon for patients to wait months or even years for treatments such as cataract operations, hip replacements, tonsillectomies, gallbladder surgery, hysterectomies, heart operations, and major oral surgery.

A Great Success? Not Quite. Just how persistent these shortages can be is seen from the recent attempt of the British government to reduce NHS waiting lists. In the spring of 1991, the British government set as a goal the elimination of waits of more than two years by the spring of 1992. In April 1992, the government announced that the number of patients waiting two years or more for treatment had indeed been cut from 50,000 patients to 1,600 patients and that waits of over two years had been completely eliminated in 153 of 186 district health authorities. William Waldegrave, Britain's Health Minister at the time, termed this "an outstanding success" and recalled that in 1986 the figure had stood at over 90,000.¹⁴

Critics charged that the reduction in waits of over two years merely had come at the expense of an increase in waits of between one and two years. The waiting lists, in other words, had not so much been cut as rearranged. In July 1992, the annual survey of the National Association of Health Authorities and Trusts lent support to claims by both the government and its critics. It reported that the two-year waiting list had indeed been reduced by 97 percent, and

12 The figure reported in April of 1992 was 925,663. See: David Fletcher, "Hospitals' Two-Year Waiting List Slashed From 50,000 to 1,600," *Daily Telegraph* (London), April 3, 1992.

13 Michael A. Walker, Joanna Miyake, Steven Globerman, and Lorna Hoye, "Waiting Your Turn: Hospital Waiting Lists in Canada," *Fraser Forum* (The Fraser Institute, Vancouver, B.C.), February 1992.

14 David Fletcher, "Hospitals' Two-Year Waiting List Slashed from 50,000 to 1,600," *Daily Telegraph* (London), April 3, 1992. An English school teacher of the author's acquaintance told how she spent nine years waiting to have her wisdom teeth extracted under the NHS. She spent four and a half years on one waiting list while attending college. Following graduation, she found employment in another part of the country where she spent another four and a half years on another waiting list before the operation was performed.

that the number of patients waiting between one and two years had also been cut by 40 percent. But the overall reduction in the waiting lists was only 3 percent, and the number of patients waiting six months or less had actually grown by 10 percent over the previous year. The survey attributed most of the success in reducing waiting times to the government's increasing the NHS budget by 13 percent in 1991—hardly an example of health care spending restraint.¹⁵

Not surprisingly, given this sorry record, a growing number of Britons are turning to the private health care market. While this is a positive development, it is, of course, also a classic example of economic activity flowing from controlled to uncontrolled sectors (*Side Effect #3*). Today, approximately 6.6 million Britons—including middle-income and even unionized workers—are covered by private health insurance, and even more do not bother to buy private health insurance but simply pay cash for operations in private hospitals rather than wait for treatment under the NHS.

Canadian Experience. Shortages produced by global budgets in the Canadian health system are less severe than those found in Britain. But Canada's track record in controlling health care costs with budget limits also is much less impressive.

Unlike Britain, the Canadian federal government does not impose a national health budget on the provincial governments, who are responsible for most of the financing and virtually all of the management of the system. But in recent years, the Canadian federal government has tried to keep its spending down by steadily reducing the size of its contribution to provincial health plans, from the original 50 percent to less than 38 percent today.

Until recently, Canada's provincial governments also have been rather lax in enforcing global budgets on hospitals. The result: Canadian health spending, when measured as a percent of GNP or in per capita terms, is the second highest in the world after the U.S. Furthermore, the rate of growth in Canadian health spending during the last two decades has been virtually identical to the U.S. growth rate.¹⁶

Provincial governments are well aware of these budget realities, and are now stricter in enforcing global budgets on their hospitals. The results are quite predictable, given the long history of price controls. In addition to growing waiting lists (*Side Effect #7*), there have been cutbacks in services as hospitals eliminate beds, temporarily shut down departments, and periodically lay off staff to meet their budgets (*Side Effects #1, #2, and #6*).¹⁷

Closer examination of the Canadian system, moreover, reveals some puzzling statistics. While Canada has only a 5.2 percent higher rate of hospital admissions than in the U.S., Canadian hospitals have 29 percent more beds per 1,000 population than their American counterparts; a 27 percent higher bed occupancy rate; a 52 percent longer average length of stay rate;

15 David Fletcher, "NHS Treats Record Number of Patients: Two-Year Waiting List Almost Eliminated," *Daily Telegraph* (London), July 23, 1992.

16 The average annual rates of real (inflation adjusted) per capita health spending for the period 1967 to 1987 are 4.38 percent per year for the U.S., versus 4.58 percent per year for Canada. Edward Neuschler, "Canadian Health Care: The Implications of Public Health Insurance," *The Health Insurance Association of America* (Washington, D.C.), June 1990, pp. 39-40.

17 For a detailed discussion and recent examples of these reductions in hospital services in Canada, see Edmund F. Haislmaier, "Problems in Paradise: Canadians Complain About Their Health Care System," *Heritage Foundation Backgrounder* No. 883, February 19, 1992.

and 63 percent more patient days per 1,000 population.¹⁸ An obvious question arises: Just what are all these Canadians doing in hospitals? The answer lies in the perverse effects of global budgets on Canada's hospitals.

Consider the incentives. For an administrator of a private American or British hospital, the incentive system is clear. The more patients he treats, the more revenue his hospital receives. But those paying the bills, whether patients or insurance companies, want the hospital to treat patients quickly and effectively, and then discharge them to recuperate in a less costly setting. These conflicting incentives encourage the administrator to make his hospital a more efficient treatment center, with shorter patient stays and a high turnover rate.

But imagine the incentives driving the behavior of an administrator of a Canadian or British NHS hospital. His budget is fixed by the government. Treating more patients will not bring in any more revenue. Instead, it will simply eat up his budget. Furthermore, treating patients with costly illnesses will consume his budget even faster. He certainly will not look competent if he uses up his entire budget before the end of the year. On the other hand, if he does not treat many patients, he will not use up his budget—but he will not look competent either. How does he respond to this very different set of incentives?

The answer is that the administrator tends to avoid admitting many patients who are costly to treat (*Side Effect #8*), but keeps recuperating patients, whose costs are lower and more predictable, in the hospital longer. As one Canadian doctor puts it, "The best way to stretch a fixed hospital budget is by keeping sick people out and healthy people in." This is why hospital stays are longer in Canada and Britain than in the U.S. and why Canadian and British hospitals tend to have a higher proportion of older patients needing less acute care services.

Such practices inevitably produce both full hospitals and waiting lists for major medical care (*Side Effect #7*). Indeed, the practice of lengthening patient stays is so common in Canada that Canadians have dubbed long-stay patients "bed-blockers," meaning they are blocking someone else's access to a hospital bed.

THE EFFECTS OF GOVERNMENT FEE SCHEDULES FOR DOCTORS AND HOSPITALS

The purest form of health care price controls are government-imposed fee schedules on doctors and hospitals. The U.S. already has considerable experience with this approach in the federal Medicare program and the joint federal/state Medicaid program. Members of Congress should ponder the hard lessons of this experience, together with the dismal record of medical price controls in other countries.

The U.S. Experience

Medicare and Medicaid, created in 1965, initially paid hospitals on a "cost plus" basis—meaning the government paid the cost of treating a patient, plus a fixed amount or percentage. Both federal programs also paid doctors according to a system of Customary Prevailing and Reasonable (CPR) or Usual Customary and Reasonable (UCR) charges. This meant doctors

¹⁸ Neuschler, *op. cit.*, pp. 18-19.

were paid basically whatever they charged for treating Medicare or Medicaid patients, provided the amounts were comparable to what they charged other patients and to what other doctors in their area charged for the same services.

This open-ended reimbursement policy was, of course, an open invitation to runaway spending. And by 1970, only five years after the two programs were created, spending on them was outstripping all previous official government projections, with even worse to come.¹⁹ By 1985, the cost, in constant dollars, of Medicaid was three times what it had been in 1970 and the cost of Medicare almost quadrupled during the same period.

In an attempt to control costs, Congress in the 1970s began to enact various restrictions on the rates paid by Medicare to doctors and hospitals, while state legislatures imposed similar limits on their Medicaid programs.

The first comprehensive price control measure was a new system for paying hospitals under Medicare called the Prospective Payment System (PPS), which took effect in 1983. Under PPS, Medicare established a fixed schedule of fees that it pays hospitals based on the classification of each patient's illness into one of 487 Diagnosis-Related Groups (DRGs). Separate DRG rates apply for different geographic areas, and the rates are adjusted annually to account for changes in a variety of factors which affect the cost of operating a hospital.

Congress enacted a second, and even more sweeping, reform of Medicare's physician payment system in 1989. The new price control structure is called the Resource-Based Relative Value Scale (RBRVS), and is being phased in over the 1992-1996 period. The RBRVS is coupled with controls on the volume of physician services in the Medicare system, plus a limit on the practice of "balanced billing," under which the doctor can charge a patient over and above the Medicare-approved fee.

The RBRVS is based on a complex, theoretical calculation of the supposedly objective value of a doctor's work, including the time and other resources required to produce a medical service, adjusted for differences in geography, practice costs, specialty training, and assumptions about the relative value of different treatment styles. It is applied to approximately 7,000 "procedure codes" for specific treatments performed by over 500,000 doctors. The result is a ranking of the "relative value" of each of those medical treatments, multiplied by a fixed dollar amount to yield a set of payment rates. This fixed dollar amount, or "conversion factor," is to be adjusted annually by Medicare to reflect changes in inflation, the number of beneficiaries, medical technology, and other factors.²⁰

19 Medicare Part A (Hospital Care) was originally projected to cost: \$2.9 billion in 1970, \$5.5 billion in 1980, and \$9.1 billion in 1990. The actual costs were: \$4.9 billion in 1970, \$24.3 billion in 1980, and \$66.7 billion in 1990. See Robert J. Myers and Charles B. Baughman, "History of Cost Estimates for Hospital Insurance," U.S. Department of Health, Education and Welfare, Social Security Administration, Office of the Actuary, Actuarial Study No. 61, December 1966, p. 48; and Committee on Ways and Means, U.S. House of Representatives, "Background Material and Data on Programs Within the Jurisdiction of the Committee on Ways and Means," May 15, 1992, pp. 188-189.

20 The formula for making these calculations is: "Payment = [(RVU_{w_s} x GPCI_{w_a}) + (RVU_{p_s} x GPCI_{p_a}) + (RVU_{m_s} x GPCI_{m_a})] x CF" For a complete description and analysis of the RBRVS system, see Robert E. Moffit, "Comparable Worth for Doctors: A Severe Case of Government Malpractice," Heritage Foundation *Background* No. 855, September 23, 1991.

Doctors: To Calculate the Impact of Medicare Payment Reform on Your Practice, Follow These 11 Simple Steps

Congress recognized that one effect of controlling the fees of doctors would be that many would simply increase the volume of services to maintain their total income (*Side Effects #2 and #9*). So another feature of the 1989 system is Medicare Volume Performance Standards (MVPS). If spending in one year exceeds the targeted amount, then the conversion factor for the following year is reduced, thus generating an aggregate cut in Medicare payment rates to doctors.

Far from being a success, these Medicare reforms and related price controls imposed by states on their Medicaid programs have created numerous problems. The overwhelming task of central planning required to administer such a complex price control regime has resulted in planners at the Health Care Financing Administration (HCFA), the agency that runs Medicare, getting a lot of the "values" of medical services "wrong." In many instances, the initial reimbursements, based on the federal government's calculations of the "value" of medical services were plainly absurd, such as HCFA's June 5, 1991, determination that 50 minutes worth of psychotherapy was equal to draining a finger abscess.²¹ A more recent anomaly is that when total reimbursements are adjusted for differences in the number of hours worked by doctors in different specialties, dermatologists will be paid an effective hourly rate 15 percent higher than that for neurosurgeons.²² In fact, the task of trying to set realistic price controls is so complex and self-defeat-

Find Total 1991 Medicare Revenues

- 1 From billing records, determine your 1991 Medicare service volume by CPT code.
- 2 Multiply volume for each code allowed amount if participating or limiting charge if not. If not participating, figure the proportion of claims on which you accepted assignment for each service and adjust charges accordingly.
- 3 Add up charges for each code to arrive at total 1991 Medicare billing.
- 4 Subtract uncollected Medicare bills from total to arrive at total revenues.

Estimate 1992 Billing Mix

- 5 Delete from 1991 Medicare volume figures all visits and consultations coded 90000 to 90699 and 90750 to 90764. Bring forward 1991 volume for all other codes to serve as 1992 estimates.
- 6 Using the new code definitions for evaluation and management services (those numbering 99201 to 99275 in the 1992 CPT manual), track volume of visit and consultation codes for Medicare patients. Two weeks should be enough to get an idea of your new visit code volume, but you may want to track volume longer to reach a more accurate estimate.
- 7 Multiply two-week volume for each new code by 26 (52 weeks divided by 2) to arrive at 1992 annual volume estimate for evaluation and management services. Adjust for anticipated seasonal volume changes, if any.

Estimate 1992 Medicare Revenues

- 8 Multiply 1992 volume estimates for all codes by new allowed charges if participating and new limiting charges if not participating. If not participating, figure proportion of 1991 volume by code accepted on assignment and reduce billing estimate accordingly.
- 9 Add up billing estimate for each code to arrive at total 1992 estimate.
- 10 Figure proportion of 1991 uncollected Medicare bills to total 1991 Medicare bills. Subtract same proportion from 1992 billing estimate to arrive at 1992 revenue estimate.

The Bottom Line

- 11 Subtract 1991 revenues from estimated 1992 revenues.

Source: Howard Larkin, "Gauging the Impact of RBRVS: Complex Task Involves Learning Details of System," *American Medical News*, December 23/30, 1991.

21 *Ibid.*, p. 12.

22 James V. Maloney, Jr., "Commentary: The Resource-Based Relative Value Scale," *Journal of the American Medical Association*, Vol. 268, No. 23 (December 16, 1992), pp. 3363-3365. While neurosurgeon are still paid at higher rates per procedure and still earn higher incomes than dermatologists, because they work much longer hours their effective hourly rate is projected to be lower.

ing that HCFA officials cannot even comply with the information-gathering necessary to meet congressional standards for fee-setting now set in law.²³

As difficult as it has been for HCFA to develop and implement this complex price control system, it has been a nightmare for physicians to even understand it, let alone comply with it. The accompanying chart outlines the steps that each doctor must go through to calculate the expected change in his or her income resulting from the new Medicare payment system.

The Side Effects of Price Controls

Beyond enormous internal problems of administration and management, the Medicare fee system is generating the typical economic consequences of any price control regime. For example, doctors and hospitals have compensated for government-imposed fee controls in Medicare by increasing their unregulated charges to privately insured patients (*Side Effect #3*). This "cost shifting" has brought understandable howls of complaint from private insurers and businesses who fund and administer most of the U.S. private health system. In response, congressional advocates of price controls now argue that government should try to stop this cost shifting by requiring private insurers to also adopt Medicare's fixed rates. Representative Dan Rostenkowski, the Illinois Democrat, for instance, last year introduced a bill (H.R. 3205) to do precisely that, and extend the complex and cumbersome Medicare price-fixing scheme to the entire private health care economy.²⁴

Doctors and hospitals are responding to Medicare's price controls with other stratagems well known to historians of the failure of price controls. One of the more common practices is "unbundling"—that is, dividing a course of treatment into discrete elements and charging separately for each item and service to obtain a greater total reimbursement. Another is called "upcoding"—meaning that in situations where the patient's illness might fall under one or more treatment categories, the doctor simply bills Medicare for the category that pays the highest fee.

Indeed, a whole private sector consulting industry has sprung up selling conferences, manuals, and computer software designed to help doctors and hospitals outmaneuver price controls (*Side Effect #9*). For example, a brochure for the 1993 edition of one such product for hospital officials claims that, "...the *DRG Working Guidebook* helps you check whether cases are being assigned to the correct and highest-paying DRG allowed." In similar fashion, a direct mail solicitation for the 1993 edition of another handbook and companion software is headlined, "Get every Medicare dollar you're entitled to under the new RBRVS payment system."

23 Moffit, *op. cit.*

24 Ironically, one of the reasons Congress imposed price controls on doctors and outpatient treatments in the 1989 Omnibus Reconciliation Act was because of cost shifting *within* Medicare. As former HHS Chief of Staff Thomas Burke noted at that time, "From 1981 to 1987, costs per outpatient visit increased 88 percent and the number of outpatient visits per 1,000 persons covered increase 26 percent. Inpatient days for this same period fell 26 percent, whereas the cost per inpatient case rose 77 percent. Outpatient costs can now range up to 80 to 90 percent of inpatient costs. Twenty percent of hospital revenues now come from outpatient care. What this seems to indicate is that, as the Medicare program has ratcheted down on inpatient Part A costs, physicians have been quick to move workloads to an outpatient setting where they can still be reimbursed on a cost basis." Thomas R. Burke, "A Proposal to Provide and Improve Access to Affordable and Accessible Health Care to All Americans," Testimony before the U.S. Bipartisan Commission on Comprehensive Health Care, October 24, 1989, p. 4.

Yet another common response of doctors and hospitals to price controls is to increase the volume of services they provide to compensate for income lost to price reductions. This “gaming” of the system includes such things as shortening the time of each office visit, but increasing their number, and ordering unnecessary tests and treatments (*Side Effect #9*). The new RBRVS rates include downward adjustments of fees to compensate for the expected cost of the anticipated increases in volume. But the effect of this will be that doctors who are adept at gaming will maintain their income, while other doctors will see their fees and income steadily fall. Over time, as Medicare fees are cut and tighter controls are placed on the volume of Medicare services, the results will be declining quality and providers exiting the market (*Side Effects #2 and #1*). The ultimate victim of course, will not be the physician but the patient.

This has already happened in some states which severely restrict Medicaid payment rates. Many doctors now simply refuse to see Medicaid patients, or have moved away from areas with a high concentration of Medicaid beneficiaries. At the same time some other doctors maintain a profitable practice seeing only Medicaid patients, running what are derisively called “Medicaid Mills.” These doctors see each patient for five minutes, prescribe a few simple tests and drugs, and then bill Medicaid separately for each item. Thus, Medicaid’s price controls simultaneously produce shortages (*Side Effect #1*), discrimination against patients (*Side Effect #8*), and a declining quality of medical service (*Side Effect #2*). The federal government could, of course, make matters worse simply by restricting the volume of medical service to the indigent, as Oregon already has proposed at the state level (*Side Effect #7*).

THE CANADIAN EXPERIENCE

In Canada, the provincial health plan is the “single payer” for physician and hospital services. Each provincial plan reimburses doctors in its province on a fee-for-service basis according to a fixed schedule of fees periodically negotiated with the provincial medical association, a system very similar to Medicare’s new RBRVS system. As a condition for receiving reimbursement from the provincial plan, doctors are forbidden by law from accepting payment, in whole or in part, from patients or private insurers.

Naturally, Canada has experienced a significant rise in the volume of health care treatments because the Canadian provinces have tried to control health spending by restricting doctors’ fees. According to one analyst, between 1971 and 1985, “the increase in the level of U.S. physician fees exceeded general inflation by 22.3 percent, in sharp contrast to Canadian physician fees which fell 18 percent behind inflation.” But during the same period, “per capita utilization of physician services grew much more rapidly in Canada—67.8 percent, compared to 49.4 percent in the United States. Perhaps more significantly, utilization per physician over the same period rose a total of 25.1 percent in Canada, but only 7.0 percent in the United States.”²⁵

Another analyst found that, “Provincial attempts to control health budgets by restricting doctors’ fees have failed. From 1972 to 1984, the provinces cut fees by 18 percent in real terms, but by an amazing coincidence, doctors’ total billing claims rose by 17 percent. Similarly, when Quebec froze doctors’ fees in the early 1970s, and their real-dollar value dropped 9 percent from 1972 to 1976, doctors increased their billings by almost the same amount, 8.3

25 Neuschler, *op. cit.*, pp. 30, 32.

percent. Alberta froze medical fees in 1984, but doctors upped their gross incomes that year by more than 12 percent."²⁶

Some Canadian provinces have responded to these price control evasions by doctors with yet another layer of restrictions. Since the mid-1970s, Quebec has set limits on the total billings individual physicians can charge to its plan each calendar quarter. If a doctor exceeds the cap, the province reimburses billings above the cap at only 25 percent of the already low fee schedule, virtually guaranteeing that doctors will lose money on each additional service they provide. In 1991 the provinces of Ontario and Newfoundland adopted similar measures, and other provinces are considering them as well. But, two weeks after Ontario's government reached agreement with the Ontario Medical Association (OMA) on the new billing limits, a Canadian Press Association story reported that, "A U.S. company's job fair to lure Canadian doctors south drew a flood of Toronto physicians who say they can't afford to practice medicine here any more...."²⁷

Thus Canadian price controls on doctors, in spite of their poor track record of controlling health spending, have succeeded in creating shortages (*Side Effect #1*) as doctors limit their services to stay within budget caps, leave Canada altogether (*Side Effect #3*), or refuse to practice in less attractive, usually rural, areas (*Side Effect #8*).

THE JAPANESE EXPERIENCE

Unlike the Canadian system, in which provincial governments are the single payers for health care services, in Japan only 37 percent of the population is covered by the locally administered National Health Insurance system. The other 63 percent are covered by one of almost 1,900 employment-based health plans. These plans are regulated by the government as quasi-public entities, offering essentially the same comprehensive set of benefits, and are required to pay providers according to a uniform fee schedule established by the national government.

Some American advocates of price controls see imposing such a Japanese-style uniform national fee schedule on both the public and private sectors, as a way to control U.S. health care spending. They believe it would lead to less disruption of the present system than would result from adopting the Canadian approach of total government funding.

But a recent review of the Japanese health system by Professor Naoki Ikegami of Keio University, notes some of the negative effects of Japan's government-enforced uniform fee schedule.²⁸ One of these is that Japanese doctors, like their colleagues in the U.S. and Canada who are subject to price controls, typically respond by increasing the volume of services. According to Ikegami, "In outpatient care, a clinic physician sees an average of 49 patients per day; 13 percent see more than a hundred."²⁹ Of course, such a case load can only be sustained by

26 Milton Terris, "Lessons from Canada's Health Program," *Technology Review*, February/March 1990, p. 31.

27 Canadian Press Service, "Flood of Canadian Doctors Turn Out for U.S. Job Fair," *The Evening Telegram* (St. John's Newfoundland), May 23, 1991.

28 Ikegami, a psychiatrist, is a professor of health and public service management at Keio University and a professor of hospital and medical administration at Keio's School of Medicine. Naoki Ikegami, "Japanese Health Care: Low Cost Through Regulated Fees," *Health Affairs* Fall 1991.

29 *Ibid.*, p. 103.

drastically reducing the time spent per patient visit, and thus sharply reducing the quality of service provided per visit.

Ikegami notes that, "While patients have ready access to care, consultation times are short, and patients end up paying repeat visits to the clinics."³⁰ Data from a recent survey of the living conditions of the elderly in five nations confirm this. The survey found that during a six-month period, the average number of physician visits per senior citizen was 3.6 in the U.S. compared with an astounding 17.3 in Japan, while the average length of visits was 30 minutes in the U.S. compared with just 12 minutes in Japan.³¹ Thus, as price controls have reduced quality (*Side Effect #2*) Japanese doctors and patients have responded in a classic fashion. They have created a new market clearing price (equal to the controlled price) at which they buy and sell an inferior quality product (short visits).

For Japanese consumers (patients) to obtain the product they desire (adequate physician services), they are forced to buy the product frequently in small increments. The added costs this inefficient system imposes equal the direct costs (such as transportation) plus the indirect costs (time spent travelling and waiting instead of on more productive activities) associated with otherwise unnecessary multiple doctor visits. Thus, Japanese doctors and patients have created a costly method for allocating the controlled product, which is yet another predictable effect of price controls (*Side Effect #7*).

This also leads to still more negative effects, as Ikegami notes:

Because Japan's fee schedule guarantees uniform payment to all providers, on the assumption that their quality is uniform, no real incentives exist to maintain quality. No formal quality assurance programs exist, and specialty boards do not contribute much to quality assurance. Under these circumstances, the increasingly quality-conscious public has turned to the large public and teaching hospitals, perceiving that their quality is higher. This has resulted in long queues in their outpatient departments (appointments are not the general rule even in these hospitals) and waiting lists in their inpatient departments. As a consequence, a black market exists for those who can afford it. Using the channel of a monetary gift in the range of one to three thousand dollars to the attending physician in a Tokyo university hospital, which is socially prescribed, a patient choosing a private room can be admitted sooner and can be treated by a senior specialist.³²

In addition to reporting the unsurprising news that price controls generate shortages (*Side Effect #1*), black markets (*Side Effect #5*), and queuing, waiting lists and bribery (*Side Effect #7*), Ikegami also raises, in the above passage, another issue; the inherent inability of price-controlled fee schedules to account for quality differences. As Ikegami notes, Japan's uniform fee schedule means that for any given procedure, "the same fee is paid by all insurers to all providers, regardless of whether the service is performed in a tertiary hospital or a rural clinic, by an experienced specialist or a recently qualified physician."³³

30 *Ibid.*

31 Diane Rowland, "A Five-Nation Perspective on the Elderly," *Health Affairs*, Fall 1992, p. 211.

32 Ikegami, *op. cit.*, pp. 103-104.

33 *Ibid.*, p. 90.

This same problem now confronts the U.S. Medicare program as it begins to implement the Resource-Based Relative Value Scale for paying physicians. While quality and benefit are the two things consumers most desire in medical care, the RBRVS system contains no method for including them in its complex calculations of the theoretical value of a doctor's services. Unlike the Japanese system, the U.S. Medicare program does operate quality assurance programs, which it continues to expand and refine. There are limits, however, to the effectiveness of such bureaucratic solutions. At best, they can only reduce or eliminate the more egregious incidents of poor quality care. At worst, they can add enormous complexity and cost to the system, generating mountains of time-consuming Medicare paperwork, eventually driving frustrated doctors out of the Medicare program (most likely the best ones) and discouraging technological innovation in medical treatment of the elderly.

As a leading U.S. health policy expert, Frank Sloan, Professor of Economics at Vanderbilt University, observes, "One would like to pay the talented hand surgeon a high price and the blundering hand surgeon a pittance. As a practical matter a relative value scale cannot make this type of distinction."³⁴ It is a critical distinction that no bureaucratic price control regime has ever been able to make.

In contrast, Ikegami notes the curious rationale for Japan's uniform fee schedule: "In Japan, the fee schedule is uniform to all providers, for reasons of both cost containment and equity. The argument is that since an equal level of services should be provided to all, there should not be any differences in quality of provider."³⁵ Thus, Japanese policy makers evidently believe that if all doctors are paid equally, they will, magically, all provide equal quality service and thus all citizens will receive equal benefits. It would seem, however, that the Japanese citizens bribing their way into the (perceived) better hospitals do not share that faith.

THE GERMAN EXPERIENCE

Germany operates a physician payment system similar to Japan's—and with some similar results. For example, the annual number of physician contacts per capita in the U.S. is 5.3. The annual number in Germany is 11.5, the second highest rate in the industrialized world (exceeded only by Japan's 12.9 rate).³⁶

The German system also indicates the folly of setting controls on daily hospital rates. In the U.S., most private insurance plans limit the in-hospital days they will reimburse fully for certain treatments, although generally there is flexibility in these limits. The Medicare system pays hospitals a fixed amount per case according to the illness being treated. As such, U.S. hospitals typically lose money if they keep patients too long and gain money if they treat and discharge them sooner. This set of incentives has, in recent years, brought about a substantial reduction in the length of hospital stays, a reduction in the number of hospital beds, and lower bed occupancy rates due to higher patient turnover.

34 Frank Sloan, "The Relativity of Prices to Medicare," in H.E. French III, ed., *Regulating Doctors' Fees: Competition, Benefits and Controls Under Medicare* (Washington, D.C.: The AEI Press, 1991), p. 72.

35 Ikegami, *op. cit.*, p. 107.

36 George J. Schieber, Jean-Pierre Poullier, and Leslie M. Greenwald, "Health Care Systems in Twenty-Four Countries," *Health Affairs*, Fall 1991, p. 31.

Hospitals in Germany, on the other hand, are paid the same, fixed per-day rate for each patient, regardless of the patient's illness or treatment.³⁷ Until recently, Germany did not attempt to limit a hospital's total income through global budgets either. Thus, the incentive for German hospitals is to recoup the expense of treating costly cases by keeping those patients in the hospital longer. That is why Germans experience longer hospital length of stay rates, a greater population to hospital bed ratio, and high bed occupancy rates due to keeping more patients in hospital for longer periods.

The different effects of these reimbursement schemes are revealed in recently published figures for acute care hospital utilization in seventeen Western nations in 1988.³⁸ The U.S. had the third lowest ratio of beds to 1,000 population (3.8), while Germany had the second highest (7.4). The U.S. had the fourth lowest average length of stay rate (7.2 days), while Germany had the third highest (12.7 days). The U.S. had the lowest hospital occupancy rate (65.5 percent) while Germany had the second highest (85.5 percent). Only Iceland outranked Germany in all three categories. Today, one of the leading concerns of German health care policy makers is how to reduce hospital utilization. Interestingly, one solution favored by some German health care experts is to replace Germany's current hospital price control system with one modeled on the U.S. Medicare program's Prospective Payment System.

THE FOLLY OF PRICE CONTROLS ON PHARMACEUTICALS

One of the easiest political targets in the current health care debate is the pharmaceutical industry. Patients are aware of the cost of drugs because they pay a larger share out-of-pocket for drugs than for most other medical goods and services. Members of Congress, consequently, can win easy applause when they complain that drug industry profits are too high. Indeed, drug companies in the 1990s seem destined to play the same role of villain as the oil companies played in the 1970s: the target of popular frustration and prime candidates for price controls. But if Congress adopts price controls on prescription drugs, it can expect results similar to the disastrous effects of price controls on oil and natural gas.

The most damaging effect of price controls on pharmaceuticals is that they will discourage spending by drug manufacturers on research and development of innovative new drugs, just as controls on oil and natural gas discouraged new exploration and drilling. When price controls are imposed on any industry, they reduce returns on investment and thus reduce the ability of producers to fund research, development, or increased production. And they discourage outside investment in the controlled industry, as investors find that they can get a better return elsewhere (*Side Effect #3*).

In the case of pharmaceuticals, a leading research intensive industry, the results would be particularly damaging. A recent study calculated that during the 1980s the average cost of researching and developing a new drug for market was \$231 million.³⁹ Collectively, pharma-

37 German hospital revenues actually come from two sources using different payment methods. Hospital capital costs are funded by annual lump-sum grants from the state government. Operating costs are paid by the Statutory Health Insurers ("Sickness Funds") at a flat per patient-day rate. See Michael Arnold, *Health Care in the Federal Republic of Germany* (Köln: Deutscher Arzte-Verlag, 1991), pp. 40-42.

38 Schieber, *op. cit.*, p. 29.

39 Joseph A. DiMasi, "Rising Research and Development Costs for New Drugs in a Cost Containment Environment,"

ceutical companies currently spend almost \$11 billion annually on research and development, or approximately the same as the entire annual budget of the federal government's National Institutes of Health (NIH). Indeed, investment in research and development (R&D) by pharmaceutical companies has been growing steadily since 1970, at a rate that doubles every five years.

According to another study, pharmaceutical manufacturers invests 16.1 percent of sales in R&D. In contrast, the rest of the health care industry invests only 8.8 percent of sales in R&D, while the comparable figures for other "high-tech" industries are even lower: 7.9 percent for the computer industry, 5.5 percent for the electronics industry, and 3.7 percent for the aerospace industry.⁴⁰ This higher level of investment in R&D has helped make pharmaceuticals one of America's most globally competitive industries. In 1990, for example, nine of the world's top twenty drug companies were based in the U.S.,⁴¹ and thirty of the 66 innovative new drugs marketed worldwide between 1975 and 1989 originated in the U.S.⁴²

Advocates of pharmaceutical price controls argue that controls will not result in less industry spending on the research and development of innovative, "breakthrough" medicines. Rather, they believe controls will limit profits and force drug companies to cut -- what is in their view -- wasteful spending on advertising, marketing, and the development of so-called "me-too" drugs which offer only marginal improvements over competing products.

There are two problems with this argument. First, it fails to recognize that in any area science and technology advance more often by incremental steps than by leaps and bounds.⁴³ Second, pharmaceutical price controls produce exactly the opposite results of what their advocates intend.

Price controls in fact encourage manufacturers to shift resources from research and development to marketing. The reason: investing money in experimental R&D is much riskier than investing money in increased marketing of existing products. Only the potential of a high payoff justifies a high-risk investment. If the potential payoff is kept low by government price controls, then only low-risk investments, like increased marketing or incremental R&D, are justifiable strategies. Of course, with or without price controls, the reason for investing more in marketing is to increase profits by increasing sales volume.

Thus, if price controls induce pharmaceutical manufacturers to shift investment from R&D to marketing, and if those marketing efforts are successful, then the results are: 1) fewer innovative new drugs; 2) increased consumption of existing drugs; and 3) a consequently higher level of individual and national spending on drugs, despite lower prices. These are, of course, exactly the opposite effects of what the price controllers intended.

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40 F.J. Pinto and J.C. Shah, "The Economics of Health Care," 1991.

41 United States International Trade Commission, "Global Competitiveness of U.S. Advanced Technology Manufacturing Industries: Pharmaceuticals," September 1991.

42 P.E. Barral, "Fifteen Years of Results of Pharmaceutical Research in the World (1975-1989)," Rhône-Poulenc Santé, Paris 1990.

43 For example, consider the history of the computer industry. While there have been a number of technological "breakthroughs" which resulted in new or dramatically improved products, many advances in computers have come from incremental improvements. For a good discussion of this issue, see: Richard A. Levy, Ph.D., "Pharmaceutical Research: Therapeutic and Economic Value of Incremental Innovations," National Pharmaceutical Council, 1990.

France is a good example of how pharmaceutical price controls can backfire in just such a fashion — simultaneously destroying innovation while boosting total costs. One analyst notes that, “In France, the calibre of pharmaceutical research is seen as having deteriorated, because severe price control has encouraged French companies to give priority to small therapeutic improvements which are useful in price negotiations. Such systems tend to stifle originality and induce risk aversion.”⁴⁴ Indeed, the French drug industry produced only three of the 66 world class drugs brought to market between 1975 and 1989, while the U.S. drug industry produced thirty — or ten times as many.⁴⁵

Yet, despite lower drug prices, the French spend considerably more on pharmaceuticals than do Americans. While pharmaceuticals account for 8.3 percent of health spending in the U.S., they account for twice that level, 16.7 percent, in France (See chart on page 7). Measured another way, per-capita drug spending is almost three times greater in France (\$492 per person) than in the U.S. (\$182 per person) (See chart on page 8).

Price controls also hamper the ability of industries, such as pharmaceuticals, to compete internationally. The U.S. International Trade Commission, in a study prepared for the Senate Finance Committee, notes that, “Several countries that have implemented such programs [price controls] have seen their pharmaceutical industries weaken or shift outside their borders.”⁴⁶ The study also notes that price variations for particular drugs resulting from the imposition of different drug price control schemes in eleven of the twelve nations of the European Community have resulted in the growth of “parallel trade” in pharmaceuticals. Parallel trade refers to the practice of “brokers” buying a drug in a country that sets the price low and reselling it in countries that set the price higher, taking their profits out of the margin. For example, Glaxo makes its popular and very effective ulcer treatment drug, Zantac, in both France and Britain. In France, the price is set low, so Zantac is imported from there by British parallel traders. A recent British study of the European parallel drug trade notes even greater distortions caused by price controls:

In some cases a medicine is made in a high price country, such as Germany, and then exported to a county such as Greece where a low price has been set by the government. Parallel importers in Germany buy supplies of the medicine in Greece and re-import them to Germany. Thus the product concerned has been transported twice in order to end up being consumed in the country where it was made. The absurdity of this is clear. In a properly working market redundant activities such as double transporting would disappear.⁴⁷

These and other distortions induced by price controls so far have had only limited adverse effects. But there is growing concern in EC nations that maintaining such controls could severely damage European drug companies, adversely affecting trade with the rest of the world. Consequently, there is new interest in restoring free pricing policies in pharmaceuticals as part of the EC move for greater European economic integration.⁴⁸

44 Heinz Redwood, "The Price of Health," The Adam Smith Institute, London, 1989, p. 42.

45 Barral, *op. cit.*

46 ITC, *op. cit.*

47 M.L. Burstall, I.S.T. Senior, *Undermining Innovation: Parallel Trade in Prescription Medicines* (London: Institute of Economic Affairs, 1992), pp. 16-17.

While artificially cheaper drugs may be a politically attractive idea, the reduction in both economic and medical benefits to Americans would be an extremely high price to pay. Moreover, even if price controls had any merit, pharmaceutical companies would hardly be a sensible target. As already noted, the share of U.S. health expenditures devoted to prescription drugs (8.3 percent) is not only one of the lowest in the world, but has also been steadily declining. By comparison, in 1965 drugs accounted for over 12 percent of U.S. health spending. Of course these figures are skewed by the fact the overall health spending has been rising rapidly. Thus, a better comparison is that while total health spending has grown from 6 percent to 12 percent of GNP since 1965, the percent of GNP spent on drugs has remained constant at 0.8 percent during the same period. In other words, Congress is dealing with an industry that has an absolutely flat level of spending, relative to GNP, for 25 years. If nothing else, the data should convince policy makers that the sources of escalating health care costs lie elsewhere—especially in the tax distorted health care market itself. If Members of Congress want to help consumers handle the costs of pharmaceuticals, they can extend tax relief for the purchase of out-of-pocket medical services such as out-patient drugs. This reform, among others, is embodied in The Heritage Foundation's Consumer Choice Health Care Plan.⁴⁹

QUESTIONS FOR PUTATIVE PRICE CONTROLLERS

The experience of price controls and global budgets for health care in other nations raises several questions for lawmakers who advocate their adoption in the U.S.:

Question #1: *Will your proposed global budgets for health care be strictly or laxly enforced?*

It is clear from the experience of Britain, Canada, and other countries that strictly enforced budgets, especially when combined with price controls, lead to shortages and waiting lists for medical care. If congressional advocates of global budgets really are serious, then Americans now receiving good care need to be told they will get less medical treatment. And congressional lawmakers will have to hold their ground when they are attacked politically by Americans denied treatment—an unlikely act of courage.

If, on the other hand, global budgets will be honored more in the breach, as was the case during the early years of the Canadian system, they will not keep down total cost. What, then, is the point of enacting them? Half-hearted global budgets will do little or nothing to control health care costs while adding layers of costly bureaucracy to a system already drowning in government regulation and paperwork.

Question #2: *Is the federal government really capable of administering and enforcing global budgets?*

⁴⁸ *Ibid.*, p. 76.

⁴⁹ See Stuart M. Butler, "A Policy Maker's Guide to the Health Care Crisis, Part II: The Heritage Consumer Choice Health Plan," Heritage Foundation *Talking Points*, March 5, 1992.

Given the spectacular failure of past Administrations and Congresses to control the federal government's own budget, what evidence is there that they will do any better in controlling the nation's health care budget?

The U.S. does not have a parliamentary system of government, in which the leaders of the ruling party command the party discipline to override the parochial interest of individual members. Can a Congress incapable of deleting pork-barrel projects or trimming back middle-class entitlement seriously be expected to enforce global health care budgets over the objections of the members whose constituents are being denied services? In the words of Representative Jim Cooper, the Tennessee Democrat, "What are you going to do when California busts the budget? Cut off their health care? They have 52 votes [in the House]."⁵⁰ It might be noted that the Veterans Administration has been unable since 1965 to overcome congressional opposition to closing a single obsolete VA hospital.

Question #3: *Who will protect doctors accused of denying medical services because of budgetary constraints?*

The legal systems of other countries with health price controls severely restrict or all but eliminate the ability of patients to sue providers or the government for denying them medical services or delivering poor quality care. In contrast, the U.S. has experienced in recent decades a virtual explosion in medical malpractice litigation. Indeed, the malpractice crisis has spurred doctors and hospitals to practice defensive medicine—the performance of unnecessary tests and procedures primarily for legal protection. By some projections, defensive medicine now adds tens of billions of dollars to the cost of the health care system, on top of the related costs of malpractice trials and damage awards.

The malpractice problem is crucial to a policy of global budgets because in practice it is doctors and hospital administrators who will be expected to make the actual on-the-spot decisions to withhold treatments to keep within a budget. But if an angry patient or relative can sue a doctor or hospital administrator for withholding care to abide by a government budget limit, the entire system is likely to break down.

Do congressional price controllers plan to eliminate, or heavily restrict, the ability of a patient to sue providers over the denial of treatment or the provision of poor quality care? If so, that will require sweeping reforms of the legal system. The prospects for such reforms in Congress are dim. But without them there is little reason to believe that doctors and hospitals will long continue to practice medicine with government policies forcing them to deny services, while the legal system threatens to drive them into bankruptcy if they do deny care.

CONCLUSION

Forty centuries of failure should be enough to convince any policy maker that price controls are an unambiguous mistake. No matter where they have been tried, the results have always been the same. There is no reason to think health care price controls will succeed when

⁵⁰ Quoted in Susan Dentzer, "Clinton's Big Test," *U.S. News & World Report*, November 23, 1992, p. 30.

all other types of price controls have failed. Indeed, the experience of other nations simply confirms that price controls in health care produce the very same harmful effects.

If Congress really wants to tame soaring health care costs, it should start not by mistreating the symptoms with price controls, but rather by examining how the federal government's tax policies have created the problems in the first place. Then Congress should consider genuine market-based, consumer-oriented reforms which simultaneously would control costs, improve quality, and expand access to health care for all of America's families. The Heritage Foundation, among others, has proposed just such a reform plan.⁵¹ It is embodied in a comprehensive health care reform bill, S. 3348, introduced last October by Senator Orrin Hatch, the Utah Republican.

In the meantime, Congress should hold hearings and commission studies, not of the health care price control systems of other nations, but of domestic and foreign examples of cost control in market-based sectors of health care. Lawmakers might find the results pleasantly surprising. For example, they will find that:

- ◆ Even the imperfect market competition present in the 9-million strong Federal Employee Health Benefits Program (FEHBP), in which they themselves participate, has produced a rate of cost growth in that program that is lower than the growth rates of private employer-sponsored plans, despite the fact that its benefit packages have become progressively richer and that it covers over 1.5 million retirees and their families, including retirees without Medicare.⁵²
- ◆ A decade ago, the judicious application of government anti-trust policy to foster competition in vision care resulted in the growth of prescription eyeglass and contact lens centers. The result: dramatic reductions in the cost of those services and products and significant improvements in timeliness and quality.
- ◆ In the substantial and growing British private medical system, hospitals not only offer vastly better quality than their government counterparts, but compete on price as well. Some British private hospitals provide patients with a list of fixed prices in advance for procedures such as hip replacements, cataract surgery, hysterectomies, knee replacements, tonsillectomies, and gallbladder surgery. Indeed, in a move that proved quite popular, during the 1991 Christmas season a number of British private hospitals ran sales on these and other procedures—offering discounts of as much as 20 percent off their regular price—as a way to fill beds during a traditionally slow period.⁵³

51 See Butler, *op. cit.*; Edmund F. Haislmaier, A Policy Maker's Guide to the Health Care Crisis, Part III: What's Wrong With America's Health Insurance Market?" Heritage Foundation *Talking Points*, August 14, 1992; and Edmund F. Haislmaier, A Policy Maker's Guide to the Health Care Crisis, Part IV: The Right Road to Health Insurance Reform" Heritage Foundation *Talking Points*, November 5, 1992.

52 See Robert E. Moffit, "Consumer Choice in Health: Learning from the Federal Employee Health Benefits Program," Heritage Foundation *Background* No. 878, Revised edition, November 9, 1992.

53 Peter Pallot, "Christmas Discount at Private Hospitals," *Daily Telegraph* (London), December 16, 1991, and David Fletcher, "Patients Snap Up Cut Price Surgery," *Daily Telegraph* (London), December 24, 1991.

In short, lawmakers will discover that a health system that works with market forces, and not against them, is the best way to achieve the goal of controlling health care costs and expanding access to millions of Americans who do not now enjoy it.

Edmund F. Haislmaier
Senior Policy Analyst

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