

CATO INSTITUTE

POLICY FORUM

WILL MORE HEALTH INSURANCE IMPROVE HEALTH OUTCOMES?

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Panelists:

John Mirowsky, Ohio State University;

Tom Miller, Cato Institute; and

Theodore Pincus, Vanderbilt University School of Medicine

The Cato Institute

F.A. Hayek Auditorium

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P R O C E E D I N G S

MODERATOR: I would like to welcome you this afternoon to the Cato Institute, to our policy forum on "Will More Health Insurance Improve Health Outcomes?"

Let me give you a general idea of how we will proceed and then I will introduce our guests and we can get right to it. We will have our guests speak in order. And then, at the end of that, we'll have a question-and-answer period that will probably run until about 5:30 or so, in toto, and then we will have a reception afterwards.

I'm here essentially to introduce people and give you some idea of who is going to be speaking and some other background. We have three speakers today. The first will be my colleague Tom Miller, who directs Health Policy Studies here at Cato. If you know Tom very well, you'll know that he has had a varied background. He has been in journalism, in law, and in broadcasting. Tom has one of the most amazing knowledge of baseball of any person I've ever met in my life. After 14 years at the Competitive Enterprise Institute, doing economic policy, Tom was called up to the majors in 2000, and he has been pitching very well for the Cato Institute in Health Studies since then. I give you my friend, Tom Miller. I think he's still my friend.

TOM MILLER, DIRECTOR,
HEALTH POLICY STUDIES, CATO INSTITUTE

MR. MILLER: Thank you very much, John.

I am here initially to provide a little background, some framework within what's going on in research for today's topic and how it has arisen.

First, we had stupid pet tricks, then we had stupid human tricks. I am going to present today my concoction of stupid health researcher tricks. As a general overview and warning, I would suggest you be skeptical of any and all sweeping claims about single factor explanations for what improves or impairs health status and health outcomes. In particular, we should reexamine the too facile presumption that more health care is always good, and, because it improves access to more health care, more health insurance coverage is always also desirable, if not necessary.

We need to be concerned with the appropriate measure of the bottom line by focusing on the output, not the input. Health insurance only provides value to the extent that it improves health outcomes, it improves our health status, and it protects us from serious financial risk.

Now, the assumption that health insurance affects health outcomes is a longstanding one, but also a relatively soft one. Consider that it may also be held much less due to persuasive evidence than as an act of faith, or even as a cover for self-interested parties seeking primarily to get paid more predictably and more adequately for their health services invoices. Nevertheless, we are in the midst of the latest wave of megastudies that purport to cement the connection between expanded health insurance coverage -- financed by public subsidies -- and improved health. The latest entrant is the study "Care Without Coverage: Too Little, Too Late," by a committee of the Institute of Medicine, or as I sometimes prefer to call it the "Institute for More Medicine."

The study is the second of a series of six planned IOM studies along these lines. It aims to disabuse us of the notion that Americans without health insurance manage to get the care that they really need. It finds instead that working-age individuals without health insurance are more likely to receive too little medical care and receive it too late, be sicker and die sooner, and receive poorer care even when they're in the hospital for acute situations.

Of course, you always need a headline grabber in this field, and this study furnished the factoid that more than 18,000 adults die each year in the U.S. because they are uninsured and

can't get proper health care. Now, the study appears to compare working-age people with no health coverage at all with those who have relatively complete health insurance coverage. There is no noticeable effort to compare the outcomes of the uninsured with people who may have incomplete or limited coverage, such as catastrophic coverage.

There is also an earlier Institute of Medicine study which asked whether it's possible to sort out and disentangle the effects of race, socioeconomic status and insurance coverage on health. Jennifer Haas and Nancy Adler, last October, in what's called "The Causes of Vulnerability," note that most studies have examined utilization of health care rather than health status as the outcome measure, and measures of health care utilization and process of care are more strongly and consistently influenced by insurance status than are measures of health status alone.

Other factors besides health insurance remain on the table as determinants of poor health, and they include low literacy, lifestyle practices, and health benefits. Haas and Adler find that the implementation of universal coverage in other countries may narrow disparities in health utilization but not disparities in health. Ethnic and socioeconomic disparities in health persist.

Despite mixed evidence at best, though, the paper then hurtles on to a conclusion that, given the political obstacles to

other types of broad societal interventions that might attempt to reduce ethnic and socioeconomic disparities in health, health insurance may be a necessary first step toward improving health status in the U.S. In other words, why not take what the political defense gives you?

Also out last month is a lengthy study by Jack Hadley, of the Urban Institute, for the Kaiser Family Foundation, called "Sicker and Poorer: The Consequences of Being Uninsured." It notes that none of the many studies it reviews on the positive relationships between health insurance, use of medical care, health, income, and education is definitive, nor are their findings universal.

Hadley suggests, though, we should distinguish between studies that suggest little or no health benefit from additional medical care use by well-insured populations and those studies suggesting that the uninsured would benefit from health insurance coverage and greater medical care use. He does not indicate how politicians and interest groups will draw that distinction and then carefully prioritize and target narrowly any future round of expanded health insurance subsidies, however.

Hadley attempts to address the Medicaid conundrum, which involves many studies finding that people covered by Medicaid tend to have worse health outcomes than the privately insured. Indeed, he notes that in some locations care paid for

by Medicaid may not be very different from or better quality than care provided at no cost to the uninsured in public clinics and hospitals or that the uninsured -- gasp -- pay for themselves. After a lot of heavy lifting on the overall Medicaid issue, the jury, I think, remains out on that one. So Hadley then focuses more on the potential benefits of insurance for the uninsured working families who are not currently eligible for Medicaid.

Now, within the limits of mostly observational studies in this field, Hadley provides an estimated range of the quantitative effects of extending health insurance coverage to all the uninsured, and suggests that their mortality rates would decline by at least 5 percent. One of his most promising recommendations is to develop new health insurance experiments that are drawn from a population of the currently uninsured, and then randomly assign some of them to a treatment group receiving insurance coverage. We don't have that experiment yet.

But on the health economist's other hand, sometimes including the more invisible hand of the market, a number of other studies raise many questions about the "more health insurance, better health care" connection. Not all those studies point in exactly the same direction and reach an integrated, mutually consistent set of conclusions, so a dose of humility and skepticism is in order across the board. But let's start out with a broadly accepted proposition -- wealthier is healthier --

or, even more broadly, individuals with a higher socioeconomic status have better health -- and then we'll start going around in circles.

We'll start with Ellen Meara, of Harvard Medical School. Her paper is called "Why is Health Related to Socioeconomic Status? The Case of Pregnancy and Low Birth Weight." She examined pregnancy and health at birth to investigate how socioeconomic status may be related to health. She found that it is the health habits and behaviors, stupid; or it's the stupid health habits and stupid behavior -- I'm updating the James Carville in the Clinton '92 presidential campaign there.

A limited set of maternal health habits during pregnancy, particularly smoking habits, can explain about half of the correlation between socioeconomic status and low birth weight among white mothers and about one-third of the correlation among black mothers. In contrast, controlling for differential access to medical care and differences in pre-pregnancy maternal health status has no impact on differentials in health outcomes by socioeconomic status.

Well, why do health habits like smoking vary by socioeconomic status factors like education and income? It is most intriguing that Meara finds that education, as measured by differences in knowledge per se, and differences in how pregnant

women use common knowledge, account for only about one-third of the difference in health behavior -- in this case smoking. The much stronger factor in driving differences in smoking by socioeconomic status appears to be what she terms network effects at the family level, the impact of information and stigma received from those living and working near an individual, in influencing the degree to which those individuals make different investments in both health and education, such as not smoking while pregnant. So, it's also the family, stupid; or the stupid family.

Meara asks whether Medicaid spending on the poor represents the most effective way to reduce disparities in health. A number of health insurance expansions have lowered adverse outcomes among the poor, such as infant mortality, but through very intensive and very costly medical care interventions at birth, rather than preventing the prevalence of low birth weight and related conditions. She concludes that we may expect too much from prenatal programs for the poor. Infant health disparities by socioeconomic status are largely determined by disparities in health habits, and those disparities exist early in life. Even programs that redistribute income without affecting such third variables as time preferences, self-control and stress may not improve infant health.

Next up, won't national health insurance reduce differences in health outcomes so that, really, money doesn't matter as much? Well, the closest U.S. version of national health insurance and universal coverage is Medicare, for nearly all Americans age 65 and over. But recent work by John Wennberg, Elliott Fisher and Jonathan Skinner, in *Health Affairs*, shows that Medicare spending varies more than twofold among different regions, and those variations persist even after differences in health are corrected for.

Higher Medicare levels are largely independent of beneficiaries' need for services. They are due largely to the increased use of supply-sensitive services, such as physician visits, specialist consultations and hospitalizations. Higher spending in various regions does not result in more effective care or better health outcomes, but money still matters to those collecting it for providing and billing for increased levels of health services.

What about another international example? Orazio Attanasio, of the University College in London, and Carl Emmerson, of the Institute for Fiscal Studies, studied the relationship between socioeconomic status and health outcomes, or, more particularly, between mortality, health status and wealth. They used data from the British Retirement Survey, controlling for initial health status. Attanasio and Emmerson

found that wealth rankings are important determinants of mortality and health outcomes even in a country such as the United Kingdom, with universal government-run health care.

For men aged 65, moving from the 40th percentile to the 60th percentile in the wealth distribution increases the probability of survival by between 2.5 and 3.5 percentage points. The effect is slightly smaller for women.

However, Jonathan Meer and Harvey Rosen of Princeton, along with Douglas Miller of the University of California at Berkeley, would caution against concluding that dollars count more than doctors and that significant health gains can be made with relatively moderate spending for income transfers to the poor. In their paper, "Exploring the Health-Wealth Nexus," they use a more sophisticated instrumental variables procedure, with inheritance as an instrument for change in wealth. And they find no short-term impact of wealth on health, at least for as long as a five-year period.

If we want to close the health outcomes gap between rich and poor, and simply transferring money directly to poor people won't do the job, why not just throw more subsidies at the health care industry itself, so that more and better health care can be produced and then made available to everyone at lower prices? Well, let's take a look at what Dana Goldman and Darius Lakdawalla of RAND said in that regard.

They started in their paper, "Understanding Health Disparities Against Education Groups," with the widely accepted consensus view that better educated people are healthier, but then they dug a little deeper to find that health disparities actually increase as the price of health inputs fall. Indeed, government subsidies for health care research, technological progress and, ironically, even universal health insurance, may worsen health inequality over time.

What is really at work here is that the reductions in the price of health care, or expansions in the overall demand for health inputs, disproportionately benefit the well-educated. Technological progress also lowers the quality-adjusted price of health care.

All these price-reducing measures boost the overall level of health investment, which is then reflected in greater disparities across education groups. Those disparities are widest among sicker groups because they consume more health inputs. The chronically ill do learn more by doing, and they gain the most experience in controlling more of their own health investments. But, most of all, more educated people are more productive at managing their own health, and they are the first to adopt and benefit from new patient-intensive technologies.

Goldman and Lakdawalla note that health inputs under an individual's control are more important than medically intensive

inputs, and the educated use more self-managed care than the uneducated. So, if we run more escalating rounds of the medical arms race, the less educated will lag further behind and receive smaller shares of -- dare I call it -- trickle-down health care. But greater levels of schooling do improve health.

An apple a day for the teacher may keep the emergency room doctor away, but do only the dumb die young? Well, Adriana Lleras-Muney of Princeton has a new paper out this month, called, "The Relationship Between Education and Adult Mortality in the United States." It suggests not only that more education reduces mortality rates but the effect is much stronger than previously assumed.

For her experiment, she examined States that strengthened their compulsory schooling in child labor laws between 1915 and 1939. Depending on the measure she uses, an additional year of education lowers the probability of dying in the next 10 years by approximately 1.3 to 3.6 percentage points. She concludes that the benefits of education are large enough that we need to consider education policy more seriously as a means to increase health, especially in light of the fact that other factors, such as expenditures on health, have not been proven to be very effective.

Now, two caveats here. The paper analyzes the effects of increasing education from relatively low initial levels. It

does not examine for effects at higher levels of overeducation. And although she notes that compulsory school attendance and child labor laws had a positive impact on educational achievement, she does not consider how much they would later reduce access to employer-sponsored insurance coverage for young children who could not be employed directly.

I'm trying to see if anyone is awake.

If you are looking for another counterintuitive conundrum, consider questioning whether economic growth is bad for your health. Christopher Ruhm of UNC-Greensboro, in a paper called "Economic Expansions are Unhealthy: Evidence From Microdata," discovers a countercyclical variation in physical health that is especially pronounced for individuals of working age, and for employed persons and for males.

Most aspects of health worsen when the economy temporarily improves. Any reductions in stress during good economic times are more than offset by increases in workplace accidents and highway fatalities, increased smoking, reduced exercise, and heightened obesity. The negative health effects of economic expansions accumulate over several years and occur despite increased use of medical care. Let the good times roll out those caskets.

Finally, what about the largely unchallenged assumption that greater levels of health insurance coverage must be

subsidized for those people who are less likely to be fully insured in order to increase their utilization of health care services and improve their health outcomes. Harvey Rosen and Craig Perry of Princeton, in a paper called "Insurance and the Utilization of Medical Services Among the Self-Employed," analyzed how the self-employed and wage earners differ with respect to insurance coverage and utilization of various health care services.

They found that even though the self-employed received significantly smaller tax incentives to purchase health insurance and they accordingly are less likely to be insured, the self-employed are able to finance access to care from sources other than insurance. Their relative lack of health insurance does not substantially reduce their utilization of health care services, it does not create economic hardship, or have a negative impact either on their health or the health of their children.

Perry and Rosen suggest that access to health care may be responsible for only a relatively small part of health, with more important determinants being genetics, environment, and human behaviors.

Well, isn't health care, though, at least essential for financial protection against sudden health shocks? Let's turn to Helen Levy of the University of Chicago, who examined that issue

in her April 2000 paper, "The Financial Impact of Health Insurance." She noted that households may choose to self-insure by accumulating assets instead of buying formal insurance to protect their household consumption levels against health shocks. Levy found that nights spent in the hospital nor new diagnoses of various serious health conditions had a large effect on household consumption.

There was some mixed evidence that households without formal health insurance that experienced a health shock did have smaller increases in wealth, on average, than other uninsured households. So, on balance, this saving, drawing down the stocks of wealth, allowed households without formal insurance to maintain smooth consumption even when a health shock occurred. The bottom line is that lack of insurance will deplete your savings if you experience a serious health event. But isn't that why people either need to buy catastrophic insurance or self-insure by saving money?

Finally, we turn to Helen Levy again, with colleague David Meltzer of the University of Chicago, who ask, "What Do We Really Know About Whether Health Insurance Affects Health?" in a December 2001 paper. They note that very few of the hundreds of past studies establish a causal relationship between health insurance and health. They are largely dismissive of observational studies that, in their view, do not account for the

difficulty of observing truly random variation on health insurance status for causal relationships that run in both directions and for other unobserved factors.

A quick rebuttal of course is, as Yogi Berra would say, you can observe a whole lot just by watching. But they acknowledge that health insurance and health are both complex, multidimensional goods that are measured imperfectly, that they only have a limited set of experimental and quasi-experimental studies on which to draw, and that their study stops short of establishing a downstream connection between access to medical care and delivery of medical care on health.

So, after blowing away most of the past studies analyzing health insurance and health, Levy and Meltzer conclude that there may be a small positive effect of health insurance on health outcomes on those populations most likely to be the targets of public coverage expansions, but that there is also evidence that in some cases expansions in health insurance may not result in measurable improvements in health. So, once you wade your way through the various caveats, your sense of cautious uncertainty, if not humility, about what we really know should increase.

Levy and Meltzer admit they cannot say which interventions related to health insurance would be most effective in improving health. And they point out that expanding insurance

is not the only way to improve health. So it remains unsettled as to whether money aimed at improving health would be better spent on expanded health insurance or other interventions that directly target health or access to medical care, such as inner-city clinics, community-based screening programs, or advertising campaigns to encourage nutrition.

I am going to stop at this point and allow our more dedicated scholars to look at some more narrow areas of this and I may have a couple of closing comments on where we go from here.

Thank you.

(Applause.)

MODERATOR: John Mirowsky is Professor of Sociology at Ohio State, and he asked me to tell you that he will be moving to the University of Texas at Austin this fall.

John.

JOHN MIROWSKY,

OHIO STATE UNIVERSITY

PROF. MIROWSKY: I would like to start by thanking Tom Miller for inviting me to this forum, and also thanking the National Institute on Aging, which funds my research, along with Catherine Ross, on socioeconomic status, sense of control and aging, and also to remind you that, despite that fact, the

opinions that I express here are mine and Catherine's, and not necessarily those of the NIA.

I am going to talk about a piece of research that we did, that was published in *Milbank*, on looking at the question of whether medical insurance contributes to socioeconomic differentials in health. And I will give you a little background on why we got interested in this. First of all, I am a medical sociologist and so is Catherine. We are both trained in social epidemiology, and we've had experience teaching in medical schools and things like that.

And as sociologists, we graduated from graduate school, got our Ph.D.'s in about 1980, and it was right about that time that sociologists were rediscovering the correlation between socioeconomic status and mortality. And that's a funny thing to say, because for sociologists, socioeconomic status, correlations with education and income, that is their whole life. That is something they are always interested in. And yet, for a period of about 50 or 60 years, sociologists, even the ones like myself who were very much interested in health, had ignored this.

It's not that they ignored it totally, because if you had somebody who was studying smoking cessation programs or something like that, or an experiment that had a socioeconomic or social aspect to it, they would certainly, in their analyses, measure things like educational background, family and income,

and adjust for those things. And why did they adjust for them in their models? They adjusted for them because they knew that those things were going to be associated with likely response to whatever they were doing and also with health outcomes. So that raised the possibility of a spurious association and they had to take them into account.

I think the other reason why sociologists hadn't really been looking at it that much was that they really thought that the socioeconomic correlations with things like mortality were vanishing, that they were a sign of things past and were on their way out. So some demographers, in the last third of the 20th century, looking at the upcoming end of the century, asked: Is this really true? Is this socioeconomic association going away? And much to their surprise, not only was it not going away, but it was getting stronger. And it continues to get stronger to this day. And if I have the time later on, we will look at some figures that look at that.

So this reenergized social science and sociologists and people in related areas of epidemiology and public health, trying to begin to understand why do we have this association between socioeconomic status and health and why isn't it going away. Of course, the American scholars, the first thing they think of is, well, it's because we don't have a national health care system. That's the obvious thing that would come to mind. What is it

that everybody else has been doing in all the other industrialized, advanced, technological societies over the last 100 years that we haven't been doing to quite this extent?

The only trouble with that is that, at the same time that the American sociologists were discovering these things about America, that we have these large associations, they were still existing, they weren't going away, the British, who have had a national health care system for some time, were finding out the same thing. The Canadians were finding out the same thing. And, lo and behold, pretty much everybody who looks has been finding out the same thing.

So something is going on here. We find that we have these SEF's, these socioeconomic effects, and they are getting larger and larger and larger. And the question is why. So this was the context. And the other part of the context was that this was a period in time, I think, when in fact Americans were interested in this question of: Are we going to finally go to a national health care system?

So Catherine and I were looking at whether we could find any evidence that insurance status -- because when we talk about a national health care system, what we're talking about is essentially extending insurance status to everyone -- and we wondered, well, do we have any evidence that we can look at in our data that would suggest that that would be effective and

whether the lack of that universal insurance status would in any way explain some of these socioeconomic differentials in health that we observe. So that is what we wanted to do. We wanted to see whether insurance status contributes to the socioeconomic differences in health.

In order to find that out, there are some things that we know would have to be true for it to contribute to at least a part of the socioeconomic differentials. And one of the things would be that the insurance would have to be itself correlated with socioeconomic status. And that is pretty clear. People with private insurance tend to be middleclass and up. People who rely solely on public insurance tend to be lowerclass or the bottom of the working class. And people without insurance tend to be people who are somewhere in the middle and not old enough to qualify for public insurance.

The other thing that we could look for is whether there was a correlation between health and insurance status. And I think one of the things that surprised us about this, really looking at it, was that we expected that we would look in the literature and find hundreds of studies that would basically report what this correlation was. In fact, there were really fairly few studies. And most of the ones that we found just compared private insurance with no insurance. And they did universally show that people with private insurance were

healthier, by all sorts of measures, than people without insurance. But a small number also included people with public insurance in the United States, and that was mostly Medicare and Medicaid.

And when I say "public insurance," I'm talking about not people who rely solely on public insurance. So, if we divide it up into three categories, there are people who have private insurance, there are people who have no insurance, and there are people who rely solely on public insurance. And when you divide it up that way, what you find is that the people with public insurance are less healthy than the people without insurance. This may have something to do with the reason why we didn't find too many correlations published in the literature, because there is not a real clear story being told there about what the effects of insurance status are.

So we find this odd correlation, and what do we make of it and what do the people in the literature make of it? And I should say that this correlation exists for all kinds of measures of health status, whether we're talking about something as subjective as how healthy do you feel to something as objective as mortality rates. We find the same basic pattern for all of those kinds of health measures.

Most of the people who found this, one way or another, concluded in the end that it must be some kind of a spurious

association, that somehow it did not really mean what it seemed to mean. And there is an odd twist to this because, basically, I think what I tended to see in the literature was that people would say, well, we think that the benefits of private insurance that we are measuring here are real, but the deficits of public insurance are not real in some way because of the kinds of people who wind up relying solely on public insurance.

So, we really didn't know and we wanted to find out what was going on here. Remember, our main interest is to find out why socioeconomic status is associated with health outcomes and, in particular, how much insurance status could be a part of that.

So we decided to look at two things. One was could we find any evidence of an effect in terms of multiple regression analysis-type effects -- that is, derivatives or things of that nature -- could we find any evidence of an effect of insurance status on health once we adjusted for all the kinds of things that we could think about and other people could think about that might possibly have been the kinds of things that would have (a) affected a person's health insurance status and (b) also be something that would affect their health outcomes?

So we did that in our study. I will give you a little bit of the background on it just very briefly, because I don't have too much time here. This was a national U.S. study, a

telephone interview study, taken in 1995 and 1998, with about 1,500 people in the sample. We got the sample by random digit dialing. We oversampled households with people 60 and older in them. And we measured, basically, three types of health outcomes: How healthy people felt; their physical functioning -- that is, could they get up and down stairs pretty well, did they have trouble kneeling; could they read well enough with glasses; hear well enough; if they needed a hearing aid, did they have one; and things like that. So, basically, basic physical functioning things, either getting at sensory functioning or musculoskeletal functioning.

And then the third thing was a count of chronic conditions. Basically, have you ever been told by a doctor or diagnosed as having a set of diseases, and then the typical heart disease and high blood pressure, and so on.

And we looked at these outcomes and we wanted to, in particular in looking at them, deal with the question of causal order. Because one of the things that we found when we looked at the literature and the interpretation of the results regarding the correlations between health status and health outcomes was that one of the things people always said was, well, if we are looking at an association that seems to say to us that reliance on public insurance is correlated with worse health outcomes than no insurance, then the interpretation of that tended to be either

that this was because of ethnic things and racial things and education things and income things that led into both of these factors, a spurious association.

And the other interpretation was that it is somehow a reverse effect, that somehow because when we are looking at people who are relying on these kinds of insurance, we're looking at people who probably have some kind of physical health problem that qualifies them, or maybe some problem in managing life, a mental disorder or something like that, or just not a great deal of competence, that leads them to be in a situation where they have nothing to fall back on except public insurance. So we wanted to rule out the possibility that the health outcome itself was causing the insurance status. So, to do that, we measured the change in health outcome over time, reasoning that if we saw a change in health outcome over time and we correlated that with the health status at baseline, that there was no way that that subsequent change in health status could have caused that baseline insurance status because it was an event that occurred subsequently.

Now, the other thing we had to do, I think, to make the logic of that work was to also adjust for baseline health. So what we did was look at really what are basically net changes in health over time and relate them to insurance status. The things that we adjusted for then, and I will give you a list of them,

were age, sex, race, education, employment, marital status, income, economic hardship. These are all things that have been shown in the literature to be associated with health and could very well probably be associated with insurance status.

We also looked at change in employment status, change in marital status, change in income, and change in economic hardship over time. And when we adjusted for these things, this is what we found. First of all, we found that there is no difference between those with private medical insurance and those with no medical insurance in their changes in subjective health, in their changes in physical impairment, and in their changes in diagnoses counts over the three years of our study. So there was no significant difference once we adjusted for the possible confounders and also for the possibility of a reciprocal causal effect.

The better health outcomes -- this is how we read it -- seen among individuals with private medical insurance seem to result entirely from their higher levels of, or better changes in, education, employment, marriage, and economic hardship.

Now, when we looked at public versus no insurance, things were a little more complicated. We found, again, no effect on subsequent changes in physical functioning of baseline insurance status, but we did see that baseline insurance status was associated with -- that is, being on public insurance and

relying on it solely -- was associated with increases in the accumulation of diagnosed conditions and decreases in subjective health.

So, there are two things to note about this. One is that this is compared to the people without insurance, and we are adjusting for age, sex, race, education, and employment. So it is basically people who have a similar profile in terms of health effects based on those things. And what we are seeing is that the people who rely solely on public health insurance, despite those adjustments, still have significantly worse changes in the number of diagnosed conditions and their subjective health. But they weren't significantly worse in terms of physical impairment.

What do we make of this? I think what we made of this was that we think possibly what is going on here is that in fact once you take into account all of these socioeconomic factors and you rule out reciprocal effect, what you find is that there really is no differences in changes in health subsequently associated with baseline health status, but there is a difference in whether or not people are getting diagnosed. And that is influencing their judgments about their own health status. And I think that makes sense, given that you have people who are going into the health care system.

The other thing that we looked at was what would happen if we measured our effects of socioeconomic status on health with

and without adjustment for the medical insurance status. Because, basically, what we wanted to know was could insurance status really account for these socioeconomic differentials in health that we are seeing.

And based on the direct effects, adjusting for the socioeconomic factors, it looked like the answer was no. And indeed, when we look at our model, with or without those health insurance status variables adjusted, we see no real differences in the estimated effects of things like education, employment, marital status, and economic hardship. These things seem to be influencing health for reasons that have very little, and perhaps nothing at all, to do with health insurance status.

Our conclusion is that medical insurance status contributes little, or perhaps even nothing, to the socioeconomic differences in health in the general U.S. population. Socioeconomic effects on health remain substantial after adjustment for medical insurance status.

So it looks to us like solutions to the problem of socioeconomic differences in health lie elsewhere, and most likely in something that is itself a major dimension of socioeconomic status. And to segue into what will follow here, I would say that our best guess at this time is that it is primarily education level that is going to turn out to be the major factor there.

I think Tom mentioned this idea of doing a health insurance experiment, in which we take people who are uninsured and we experimentally give them insurance. I would like to get my prediction now in public and record it. I predict that what we would see if we actually do this experiment is that the medical insurance would really do little to reduce the socioeconomic differentials in health, and possibly nothing.

(Applause.)

MODERATOR: Our next speaker will be Theodore Pincus, who is Professor of Medicine at the Vanderbilt University Medical School.

THEODORE PINCUS,

VANDERBILT UNIVERSITY SCHOOL OF MEDICINE

PROF. PINCUS: Thank you very much. I appreciate an opportunity to be part of this forum.

I come at this with a very different perspective. I am a professor of medicine. I have been doing that for 30 years. which means I have been involved in patient care, teaching and research, at different periods over the years, in different proportions of that. What got me interested in this subject was a very simple analysis that was done 20 years ago now, in 1982. I had arrived at Vanderbilt, as you might be able to tell, from

the Northeast in 1980. We had a group of patients who were talking about some treatments there that were not something that I had seen previously, and I thought these were pretty good treatments but they might have severe side effects. So we had an opportunity to do a follow-up study on a very small group of patients, 75 patients.

I had a box of records that said "Jim Beam" on the side, and we managed to contact actually every one of those 75 patients, which was sort of important. We found out that the treatment had not had any severe side effect but some very interesting unexpected observations emerged, one of which was that people who had rheumatoid arthritis, which is the major condition that rheumatologists such as myself treat, actually had diminished survival. Which, at that time, wasn't appreciated. And in fact, recognizing that, I'm happy to say that, in the last few years, we've been able to correct that with medical care. So I am not a nihilist about medical care.

But we also found we could predict who was going to not survive according to two variables I had never really thought about. One was their functional status on a questionnaire, and the second was their level of formal education. After looking for viruses and other sorts of disease markers, it seemed to me that this actually made more sense than many things that I had looked at.

So we started to examine what was really going on about education level. And of course, we had the original simplistic idea that this was really a surrogate for limited access to medical care, although obviously all these patients had access to our medical system, at least at one point in time. This study actually was done over a nine-year period. But in thinking about it further, we recognized -- and this is some of the advantages, in a sense, of being at the front lines; I'm like a regular physician every Tuesday and see a group of patients -- and I recognized that this really didn't explain very much to me, but we could see the behaviors of people really differed according to their level of education.

And then we started to look in the literature, and this was in fact the period of the somewhat early eighties, or the mid-eighties, and found several studies which suggested that the explanation for the associations of education level and health could not be explained by education per se, I think by money, by differences in income, or by differences in access to care. From our own clinic, we also found that the differences in functional status over time in people who were regular attendees of the clinic varied considerably according to their education level. So that, overall, 75 percent of people with less than eight years of education had a functional loss of 50 percent or greater, or

died, with poor outcomes, compared to only 25 percent of those who had some college or more.

And I must say, the inflection point in most of our studies seems to be 12 years is the primary one, a little more at 16 years; after 16 years, there seem to be no benefits for health, and in fact there is some evidence that if the spouse has more than 16 years of education, things go the other way. That's another topic which we cannot really discuss here.

We found, in our clinic, in a simple cross-sectional study among 385 patients, that even a blood test, called the erythrocyte sedimentation rate, varied significantly according to level of education, as well as the number of swollen joints we looked at, or functional measures. We also found this to be the case in all the diseases we treat, which include things like lupus and fibromyalgia, scleroderma, and osteoarthritis as well.

In fact, what we found, and we found this in all our studies -- and I think this is true in most other studies -- is that education level is more explanatory of differences in status than age and duration of disease. You cannot publish a paper anywhere in a medical journal without information about age and duration, and it is very unusual actually that people collect in a clinical setting information about education level.

We looked in the literature and found a famous Whitehall study which was done by Marmot and Rose, published,

again, in the early eighties, which showed that among English civil servants, unskilled workers had a cardiovascular mortality of 4 percent, compared to 3 percent for clerical workers, 2 percent for the professional executive types, and less than 1 percent for administrators. You might think that this should be explained by recognized risk factors, and it turns out, yes, unskilled workers have higher blood pressure and are more likely to smoke than clerical people, than professionals. But in fact that explained only about a third of the differences, and the remainder are unexplained.

One could interpret that to suggest that lifestyle seems more important than specific risk factors in the overall cardiovascular mortality. I should point out the administrators actually had higher cholesterol levels but much lower cardiovascular mortality.

There is a study, a famous clinical trial, called the Beta Blocker Trial, in which a group of patients who had a heart attack, or a myocardial infarction, were given either propranolol, a beta blocker, or placebo. And there were significant advantages to the beta blocker. Which this trial was done in the early eighties, and many people have taken these drugs to some advantage over the years. But what was curious -- and this is in a sense the closest thing to the controlled experiment of uninsured and insured because a clinical

trial is the ultimate insurance, the doctor actually calls you if you don't show up and wants to find out what happened -- and over a three-year period, the people who had less than 10 years of education had a 14 percent mortality rate compared to 5 percent for those with more than 12 years, despite the fact that they were all involved in this protocol.

Obviously one has to consider antecedent events but, over this period, it's a very striking phenomenon. In fact, the education level was more significant than whether patients were randomized to drug or placebo.

Our own studies of population-based data indicated that there was a much higher prevalence of disease according to education level. There is three times as much likelihood of people in the United States under age 65 to have arthritis, hypertension, peptic ulcer, pulmonary, lung, or kidney disease, but not allergies, thyroid disease. And multiple sclerosis, curiously, is a disease of upper classes. So that it is not a simple artifact of a study and it was very striking.

In fact, not finishing high school is a much stronger risk factor for developing heart disease, for example, than high cholesterol, blood pressure, and smoking put together. And these are partially explained by that phenomenon, but this is a very serious risk factor.

It is worth noting that in the United States in 1965, 6 percent of the GNP was spent on education and 6 percent on health. In 1999, it was 14 percent on health and 7 percent on education. And I have said to my colleagues that it seems to me, if we are really concerned about health, perhaps at least that is an experiment that would be of interest, if 11 percent of the GNP were spent on education and 11 percent on health. Perhaps we would actually have a healthier population.

I would point out, and you have some of the frames of this in the article, Rudolf Virchow, who was actually the founder of cellular pathology 150 years ago in Germany, said the improvement of medicine would eventually prolong human life, but improvement of social conditions could achieve this result more rapidly and more successfully. And he said medicine is a social science, politics nothing but medicine on a large scale. That is sort of interesting. He was actually a member of the German Legislature.

Now, I want to spend the last couple of minutes presenting some concepts of how we got into this concept. And that has to do with what I call the biomedical model paradigm. This has been a very successful paradigm over 20th century medicine. It has some premises of sort of reductionism. One looks for a single cause. And people ask me, what's the cause

that education can be associated with health? And the answer is it's not reducible and has to be looked at in a different way.

This is a very effective model for acute diseases -- pneumonia, motor vehicle accidents, et cetera. And that is where many of our concepts of E.R. and how the public thinks about health come from. Over chronic diseases, it is limited. It says that the mind and body are not associated, which there is strong evidence that in chronic diseases of all sorts there are mind-body associations that have to do with the outcomes. The biomedical model says that lab tests are the most important information.

And actually, information from patients that we can quantitate in questionnaires seem to predict hospitalization and death more effectively than lab tests and x-rays in many kinds of diseases. And this model says the outcome depends on health professionals. This is how all medical students are taught in an in-patient hospital, where the doctor literally writes what are called orders. The doctor is in control. If he does the right thing, the patient is saved. If he doesn't, there is a poor outcome.

But over time, the patients I see in the outpatient setting, I see for 20 minutes three or four times a year, maybe an hour or two a year. The rest of the time the patient is in control. And so George Engel, a great psychiatrist, proposed

actually in 1977 a biopsychosocial model, which involved non-reductionism, or holism if you will, with mind-body connections, in which the patient's data was at least as scientific as laboratory or x-ray data and outcomes may depend as much on patients as professionals.

Now, when we look at a biopsychosocial model, then we can say that health care really has much wider dimensions than tests and drugs, that one looks at outcomes, and that insurance is not necessarily going to give us effective medical care. When one really has to examine the outcomes, such as Dr. Mirowsky has done, and when one does, one has similar kinds of conclusions to what we have seen empirically in our own clinical studies.

So in this setting, I think we have to have a plea that we need really to preserve the biomedical model. In part of my other life, I'm a very active treater of patients with rheumatic diseases, and I am very proud of the improvements we have made in outcomes over the last 20 years, but we also have to introduce this biopsychosocial model. That if patients cannot adapt the best treatments in their management with their own self-management and behaviors, we have major limitations in what we can accomplish, and we have to look for new methods to help patients to achieve better outcomes.

Thank you.

(Applause.)

MR. MILLER: I said I was going to suggest a few tentative conclusions and policy implications of today's forum. Well, particularly in the health policy field, we generally know less than we pretend to in prescribing sweeping solutions for others. But aside from my usual second-best starting point of don't just do something, stand there, what should we do next, I turn to the messy, informal combination of charity care, high-risk pools, other safety net mechanisms, emergency room mandates, personal savings, and out-of-pocket payment. It may not be elegant and orchestrated from the top of the political food chain in Washington, but generally it gets a lot of the job done in a relatively rational, prioritized manner.

Reviewing Brad Herring's paper on "Access to Free Care for the Uninsured and Its Effect on Private Health Insurance Coverage," Herring, at that time at the Wharton School, found that although access to the safety net of free care for the uninsured might make paying for private health insurance less attractive for certain households and increase their likelihood of being uninsured, the uninsured still receive some care, a little less than 55 percent as much health care on average as the insured do, yet their out-of-pocket costs for their health care are not much greater than the out-of-pocket costs for the insured.

The uninsured receive almost two-thirds of their health care "for free." Moreover, the proportion of charity care available from providers increases for uninsured individuals who face larger medical costs. The proportion of health care expenses paid out of pocket by the uninsured decreases considerably as utilization rises. And both the magnitude of out-of-pocket expenses and its proportion of total utilization are lower for the lower-income uninsured. In other words, free care through private charity and the public safety net operates kind of like a catastrophic, high-deductible insurance policy that is also sensitive to ability to pay.

Now, given the continuing disagreement about whether the reservation prices for insurance by the low-income uninsured are too high to allow modest tax credit subsidies to significantly dent the overall number of the uninsured, we might wish to reconsider the alternative of strengthening the safety net to increase the uninsureds' access to care. We could bolster financing for safety net care through increased tax incentives for donations to nonprofit health care intermediaries, and even citizen appropriations that would redirect tax dollars toward health care charities.

More general revenue financing of high-risk insurance pools would help free the rest of the private insurance market from counterproductive regulation, and allow it to do what it

does best for the rest of the insurable population. We should examine more carefully the opportunity costs of investing exclusively in expanded health insurance subsidies as opposed to freeing up resources for improved education and income protection.

We should question broad expansions of health insurance subsidies unless and until we see new evidence that initial political promises of new entitlements can ever be targeted and prioritized once they are set in motion. The political question of how much health insurance and how much health care is an adequate minimum but not too much and not too unaffordable is one that our political culture repeatedly avoids and evades answering.

We also could begin by combining steps toward greater tax parity in the treatment of how health care and health insurance is purchased with incentives to consider less comprehensive forms of insurance, such as two-tiered defined contribution health benefits plans and medical savings accounts, with tax incentives to save funds on a longer-term basis. Various vehicles to facilitate such consumer-driven health care and also deregulate the mix of insurance and out-of-pocket health spending choices would increase the role of patient self-management in their own health care.

Personally, I will be improving my own health status shortly with my daily single glass of red wine upstairs at the post-forum reception. I will be self-medicating with some preventive care in light of today's enhancement to health policy education.

Thanks.

(Applause.)

MODERATOR: Thanks to all of our speakers for those very interesting presentations. Now we will move to the question-and-answer phase. We have someone here with a microphone, so if you could wait until the microphone arrives. Please identify yourself. If you wish to direct a question to one of our speakers, please name the person.

We have a question here.

MR. GREENBERG: Bruce Greenberg, from Brinkman Publishing Company.

Two questions. First, the panelists have treated education as a black box, in essence. And as a reductionist, I would like to know what it means. Is it really the result of formal education or is it the self-selection by people to get additional years? That would be my initial starting point.

The second comment relates to the measurable effects of increased formal education in America. Political scientists believed, in the forties and fifties, that increased years of

education would lead to some moderate increases in political information among people. It hasn't. In addition, the general test scores and the meanings of test scores have declined per year of education, and we have diluted it. So back to the first question: What is the education black box? And secondly, is it really something else going on here?

PROF. PINCUS: That's a very good question, and we've obviously oversimplified it drastically. I thought you might be asking, well, does it matter where you get your education? And that is something that I don't think anyone has any information about, but it would be very interesting.

Let me say, though, that the United States, as far as I know, has had a law of mandatory education through age 14 or 16. Yet, it is still the case that in Tennessee, where I am living now, and in the Southeast in general, up to 10 percent of people have fewer than eight years of education, and up to 25 percent do not finish high school. That is the simple measure that we have used. And I would agree completely that it is greatly oversimplified.

Now, as I mentioned, there are some papers that I have read that suggest education, per se, is contributing to health. There is Michael Grossman's work. But I think that, from my perspective, this is a surrogate for many behaviors and, in a non-reductionist sense, probably hundreds of daily actions that

go on every day about health. If you think about it, most people in this room, on average, are healthier than age-matched people in the population. And it is not because of being in doctors' offices or using insurance to the maximum. So that this is where I look upon it. But maybe a social scientist could give a more erudite answer.

DR. MIROWSKY: I wish I could give a more substantiated answer. That is, I wish we had more research on this, but I guess that's giving away my own preferences. But I will just give you a couple of things that I think about it. One is that if I just tell you what I think it is, I think what's really happening in education is that people are actually learning things that give them control over their own lives.

Remember, I said that my research is on the sense of control that people have and why that tapers off at the end of life. But in following that back, I have had to look at where the sense of control people have over their lives comes from. And it is pretty clear that that comes from education. It is built in the education system, and it has a lot of consequences throughout people's lives.

And I think it is basically that health is one thing that everybody wants. We may vary in how much we value it, but it is basically something we all want. And I think that the reason we are going to discover in the end, when it is all said

and done, why education has these effects, it is that education gives people the power over their own lives to pursue whatever it is that they want or choose. And health is going to be one of those things.

Where are we at in terms of data now? We're just beginning. I can give you a couple of things that I know are true. One is that as the level of education has been rising, the effects of differences in education on health have not been going down. This is not a diminishing returns thing in that sense. If you look at the 20th century, as the levels of education went up over the 20th century, the age-specific correlation between education and mortality got larger and larger and larger.

It is also the case that as people go through life, the correlation between education and mortality goes up. That suggests that it is not just kind of a relative status thing that is happening but that there is something actually that is giving people more power over their own lives, including their own health.

Another thing is that if you look at the effect of income, or the association between income and measures of health, you get a classic diminishing return model, where the biggest slope is at the low ends of income. That is, another \$10,000 in income is going to make a lot of difference if all you have is \$10,000, and nothing if you've got \$400,000 a year. Which is

intuitive. But what is not intuitive is that a large part of the reason why that is happening down at the low end is that those people also have low levels of education. If you look at interactions between education and income, what you find is that the association between low income and poor health is much lower for people with higher levels of education.

And this is true not only within a country like the United States but it is also true internationally. That is, if you compare societies, whole countries, with a similar GNP per capita levels, the better educated ones are going to have better life expectancy or lower infant mortality rates.

So one of the things we know is that education seems to make income more effective in health terms. And I think that is another indication that people are learning things that help them pursue things in life like health.

MR. MILLER: I will be real brief. There are limitations of social science and databases, education, in terms of years served, time and place. You know, Woody Allen said 90 percent of life is just showing up. They measure the years of education and not its quality because that is the easy measure to do statistically. Clearly we would like to know about the quality, but that gets into kind of more complex judgments.

Lack of political knowledge with our increased education, that sounds like rational ignorance to me. Now, in

the case of health care and health insurance, if you give consumers the ability to make a difference with what they learn about their health care, they will be motivated to know more about their health care and make those choices.

Finally, we would emphasize that the quality of education is very important. We have a lengthy set of studies, through our Educational Policy Sector, which talk about how to give parents choice in their children's education, to get better qualitative education, primarily through tax credits and, as a second best, vouchers.

MODERATOR: Yes.

DR. SIEGEL: What you have presented is a very radical change from the way the system is going right now. And I'm going to give you a brief background for the question, and then ask you the question. I'm Dr. Siegel. I have over 20 years of experience in medicine. I also run a large distribution network for health content on over 100 Web sites. And I have attended more than 100 conferences in medicine. And I can tell you unanimously that all the health care conferences that I have attended, they all have the position which is opposite to what you presented. They all are in favor of more technology and more treatment. I'm sure you all know that. They are in favor of more information technology, more blood tests, more MRI's.

MR. MILLER: Would you simplify that to more money?

DR. SIEGEL: Well, more money spent on diagnosis treatment as opposed to more money spent, for example, on teaching people how they can change their behavior or how they can do something else. More money for medical resources.

PROF. PINCUS: More money for fixing the broken parts.

DR. SIEGEL: In my own experience, I spent several years reviewing all the cases at a major hospital in Boston on heart disease. And I was taught as a student that people who were executives with type A personalities would be at higher risk of heart disease. What I found from hundreds of patients is that I never saw a patient with a Ph.D. or higher education or a high job. All the people I got were laborers and truck drivers. And it amazed me that these were the people who were coming to the ICU with heart disease -- before your studies came.

So I think that what you are proposing is a very radical change in the way we are approaching medicine today, and I think it makes a lot of sense. I would ask you two questions related to what both of you said, and I think Dr. Pincus may want to give the first answer, which he may have, because I have read your paper. Number one, is there a possibility that we are mixing education with I.Q., and so there is some kind of inheritability and therefore we cannot just educate people? You're either smart enough and you figure it out or you're dumb

enough and you're going to drop dead. That is speaking in a tongue in cheek way of course.

And we all should be careful of giving advice, because I tell people that the best way to solve the medical problem in America of health care is to close the supermarkets for two weeks, and that would be inexpensive.

The other question is, suppose that one agreed with your position, how would you divide the dollar amounts in terms of insurance? If you were to provide now some more health insurance for the uninsured for Medicare and Medicaid, would you spend it on acute care, would you spend it on more chronic care, or would you spend more on education? Where would you set the limit about the kinds of coverage that you would provide?

PROF. PINCUS: The first question, you made the observation and I think any practicing physician observes it -- and I tell this to colleagues -- that you noticed more of the patients you see are of lower classes. That's because those are the people who get sick. And that is a reality, regardless of what you were taught. I was taught the same thing from the same textbooks, which really had the information incorrectly. However, I will make a point that is of great concern to me. As the possibilities of intervention improve and increase, the disparities between the well educated and poorly educated seem to continually increase.

I have seen this trend in asthma over the last 20 years, which had a much lower disparity in some of the studies done earlier. There is no doubt that there is some association here with I.Q. I don't think we can get away from that. We have shown that one of the worst predictors of poor outcomes in our clinic is illiteracy. Although the country music stars in our neighborhood keep having illiteracy fairs, they haven't really wiped out illiteracy. And that is a very serious issue.

What to do about that is beyond what we can answer here. But I would certainly say that if we really are serious about improving the health in the population, more textbooks might actually be more effective than more MRI scanners. And I think any sensible doctor would at least want to consider that experiment. That's all I will say about that.

MODERATOR: Another question right here.

QUESTION: I must attend different conferences, because what I'm hearing people talking about here I'm familiar with as public health and prevention health education. There is classic stuff from 50 years ago from around the world and especially associated with maternal education. So that the point where you start is not in high school but with the pregnant woman, with longevity, with increased life expectation, and so on. There is a constant plaint at public health conferences that if we can go from 1 percent to 5 percent that is spent on population health,

on improved nutrition, on improved environmental status, that that has much greater impact. I noticed that some of the papers you handed out cited that fact, that that is where the increase that happened in the 20th century was in prevention and in wellness. So I guess that is a comment.

The question I had is also in light of education in the questions raised before. I would put it in terms of not intelligence but a number of factors, whether duration of education reflects a survival bias, and that you need to take that into account when you're trying to sort that out. You have two complicated phenomena, health and education, and you are trying to figure out their interactions, but you need to think about education survival bias as well as health survival bias. And it has both what you bring in but also a lot of other factors related to the kinds of schools you're in, prejudice, economic pressures, and things like that.

One of the final things you end up with is patient self-management. And it strikes me that that seems a poor solution to be using if your problem is poor education. How do you parse out the relationship between patient self-management, including a lot of functional illiteracy and education, as already predisposing to poor health results?

PROF. PINCUS: I think that is directed at me. I would say that we want to simply call attention to some of these

issues. This paper that was distributed here was published in the *Annals of Internal Medicine*, after two years of struggling with the editors. The idea was the professional society I belong to is called the American College of Physicians, and their major plank of improving health in the population is improved access to care. And the original title of that paper was "How Much Will Improved Access to Care Improve Health in the United States?" And it was laundered and it was published with a rebuttal as well as an editorial, saying how incorrect we were.

So we were really simply trying to call attention to this problem. What we were originally saying is not self-management; we cannot teach that. I spend a lot of time in my clinic trying to teach self-management to people of lower socioeconomic status. But we have actually found that, as the treatments are more complex -- as you may know, we use biologicals now in treating rheumatoid arthritis -- and it doesn't work in people of low socioeconomic status. And we work twice as hard -- or actually we work four times as hard -- at trying to do something about it. We don't have resources for the kinds of programs that we think we would need. And basically then, access to these treatments, which now can cost \$12,000 a year, is worthless, in a sense, for people who can't take advantage of them appropriately. This is not fixing somebody in an operating room, where the end is there.

So these are very complex issues. We just want to call attention to the direction that Dr. Siegel was mentioning, that more and more resources for more services, as with business as usual in the clinic, is not going to be the solution.

MR. MILLER: Just a quick addition. Most of this analysis has been focusing on a much more mature stage of a health care system in the United States, as opposed to building up from a lower level of development. Have you exhausted the marginal returns on doing more of the same? Is it time to look in another direction when you end up hitting a wall?

MODERATOR: Yes?

MR. SCANLON: I'm Greg Scanlon, with NCPA.

I don't have a nice succinct question. I guess I'm starting with Tom's original thought, which is that we tend to oversimplify in health care. And I'm hearing clearly that there are correlations between poor health status, poor education, low income, and lack of insurance. I'm not comfortable with saying that it's education more than the other two or it's income more than the other two. It seems to me that there are a lot of factors, which kind of raises a question. Those qualities that cause people to be poor, poorly educated, or uninsured, may be the underlying qualities. Maybe it is I.Q. Maybe it's the way they were raised. I'm not quite sure what it is, but it has kind of disturbing implications.

It seems to me that many of us are cheerleaders for a new consumerism in health care. And it seems to me that, if nothing else, this is saying that some not small portion of the population is not going to be capable of being health care consumers. What does that mean? So the discussion is profoundly disturbing actually.

And just one other thought. I wish Jack Hadley were here as well to kind of bounce some of these things off of. And that's not your thought.

PROF. PINCUS: I think it is very disturbing, and that is why we want to call attention to this. Because we are not going to solve a problem that we don't understand, whether it's the cause of tuberculosis or whatever. And let me just say that the public health successes of the early 20th century generally involved interventions that did not require much effort on the part of the recipient -- vaccination, fluoridation, et cetera. It is getting more complicated now. That is really all we're trying to call attention to.

I agree that people sometimes interpret what we're saying as not caring about the underserved. On the contrary, I am very passionate about trying to do something about this. But the solutions that are being proposed now I think are not going to work.

PROF. MIROWSKY: I think it is not only that it is getting more complicated, but I think that also, in a way, we have very successfully done for people and for each other the things that we can. We have occupational safety and health programs, we have programs like the CDC. We really are protecting each other quite well compared to where we were 100 years ago. And so what is left is that part that really ultimately comes down to your own choices and behaviors, sort of aggregated over a lifetime. And I don't think we can avoid that.

MR. MILLER: We saw at an earlier stage of the education debate that we tended to want our schools to do everything. The kids come there with all sorts of problems, and then they end up becoming an all-purpose solution once you're in the school system.

I think we're more at a stage now where we're saying that somehow the health care system can deliver the right care that is going to take away all these things that were troubling you over a long lifetime that come from many sources. So we have socioeconomic problems, we have straightforward economic growth problems, you've got education problems and you've got health problems -- we're saying that you've got a lot of problems and you better sort them out in a much more complex, sophisticated manner than saying a-ha, I hold in my hand the health insurance

card which is going to take away all these difficulties if you'll just funnel some dollars into it.

In addition, on the consumer-driven care, we now see that in the current system of extensive public programs and largely comprehensive third party insurance, the folks you are worried about are not faring that well. We have not found out which of them can fare better in an environment where they do begin to make some choices and have agents who can help them and are more motivated to know what works for them in their health care. So I wouldn't close the door on finding out that in fact we have a good pool of potential opportunities there.

MODERATOR: A question over here.

MS. MILLER: I'm Wilhelmine Miller, with the Institute of Medicine. And I worked with the committee that issued "Care Without Coverage."

I wanted to say one thing about the studies that the committee reviewed and led it to conclude that in fact health insurance did make a difference in outcomes. The studies either looked at actual outcomes in morbidity or mortality indicators or they looked at paradigms of evidence-based care. And much of the evidence was on the side of chronic care and preventive services, the receipt of appropriate forms of chronic care and preventive services, rather than the acute care services at will, if you would.

So it is not that health insurance provided access to any kind of care that we concluded resulted in better health outcomes but that the care that people with insurance had -- and in some cases it was private insurance only, in other cases it was either private or public coverage, as compared with uninsured -- the big results were on the chronic and preventive services side. So I think that is something to take into account when you're talking about whether services alone are going to result in improved outcomes. It does matter if the care is evidence-based and appropriate. And that was one of the findings in the report.

MR. MILLER: I know the care is evidence-based. Often the calls for broad-based insurance, though, are not evidence-based. If you could somehow target the insurance assistance to those who need the care, in the right way and the right manner, as opposed to spraying it widely across the whole population, I think then those studies would have more power. But I've read them, and basically you make your case.

MODERATOR: One more question.

MR. NICHOLS: I'm Len Nichols, from the Center for Studying Health System Change. I want to thank Tom for inviting me.

I was sitting back there with Jack Hadley for an hour, and he had to go, I'm sorry to say. But what he said in his

parting remarks was, Len, I don't know where to start. So I will start for Jack, and we can segue into mine maybe as we go along.

What I was happy with, first of all, was Tom inviting me, but I am also disappointed, because I thought I was going to come here and hear people advocating abolishing Medicaid or something. I don't think we've gone that far. What I think we have done is made clear that on the margin it is hard to make a case that insurance per se is going to be more important than education or, in some cases, self-care, or very efficacious care if it's done particularly well.

Now, I would say that in a way you guys are attacking a straw man. I know some people say an insurance card would solve all problems. The last time I looked, they are now out of the White House. You don't have to keep beating that horse, Tom. That's kind of over. But what most of us say is that insurance is a contingent commodity. And most of us don't even know what's in our insurance packages until we get really, really, really, really sick, and then we find out what the deal is.

My point is that service that you buy that is evidence-based on the margin, if you have a good provider, you never know about ahead of time. I would say that sometimes it can be immensely valuable, and that's what some of those studies show -- survival rates from breast cancer, survival rates from very specific health problems, are much improved if you have

health insurance. There is no question about that. I don't think you guys are questioning those studies.

At the same time, there is no question that teaching children good diet and good habits is probably a better investment on the margin, a better return on our dollar, but I can't get dollars out of anybody to do that either. So it is not clear to me that you opposed universal health coverage in the name of giving money to education or free clinics unless you also get the education and free clinics some other way.

So the question is, let's talk about triage, let's talk about on the margins. It seems to me that insurance is a layer, like an umbrella, under which then you create the conditions. How are you going to educate them, Dr. Pincus, unless you get them in your office? And how are they going to come to your office if they don't have some means to do that? That is the first step.

The second step is then, can you teach them what they need to know to utilize this new technology or new information, this cutting-edge stuff? Maybe, maybe not. But I would submit that having lots of clinics out there is also a good way to do it. But at the moment, we cannot free any resources to do any of this. We are all kidding ourselves. So let's go drink.

(Laughter.)

MR. MILLER: I can't help the fact that you're a political failure.

(Laughter.)

MODERATOR: On that note, I want to thank our speakers today. And I want to thank each one of you for coming to the Cato Institute. I hope to see you again. Let's adjourn upstairs for the wine.

(Applause.)

(Whereupon, the Cato Institute Policy Forum concluded.)