Book Review by John R. Graham

The Right Prescription

Code Red: An Economist Explains How to Revive the Healthcare System without Destroying It,
by David Dranove. Princeton University Press, 281 pages, $29.95

Putting Our House in Order: A Guide to Social Security and Health Care Reform,
by George P. Shultz and John B. Shoven. W.W. Norton & Co., 244 pages, $24.95

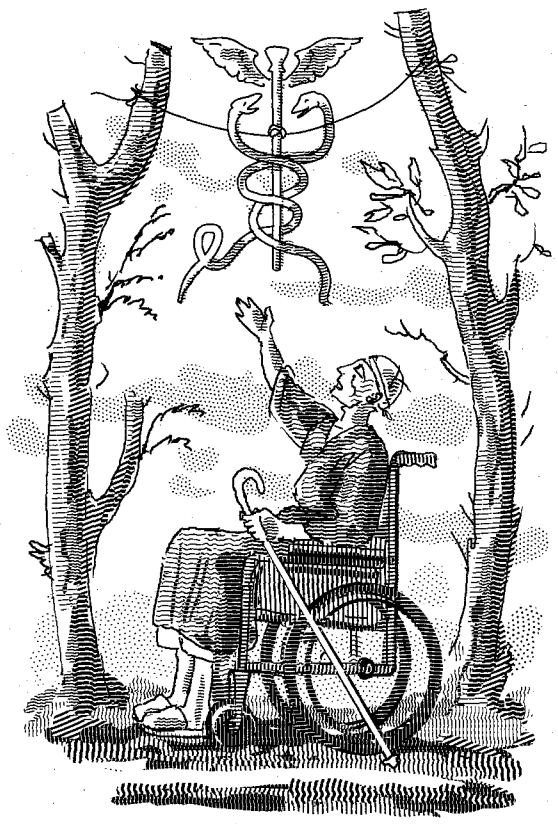
One could be forgiven for being confused about the state of American health care and, by extension, the welfare state in which it is cradled. Although perpetually threatening to unravel, with 47 million uninsured swarming around its tattered edges, American health care is also widely praised as the best in the world. This is largely because of the impressive pace of scientific innovation that has lengthened our lives and improved our quality of life, albeit at great monetary cost. For the non-expert, two new books supply excellent explanations of the condition we're in today, the direction we need to travel, and the possible ways we may provide for a future of better health care.

In *Code Red: An Economist Explains How to Revive the Healthcare System without Destroying It*, David Dranove, the Walter McNerney Distinguished Professor of Health Industry Management at Northwestern University's Kellogg School of Management, takes us on a 360-degree tour of the choices confronting our policymakers in health reform.

Dranove posits three goals for a well-functioning health care system: access, efficiency, and quality. Mercifully, he does not include "equality"—the signal that an author is about to outline a health care "system" for a utopian society in which human selfishness, parochialism, and ambition have been abolished.

Noting that "there is no free lunch, only tradeoffs," Dranove dedicates the first half of his book to an enlightening description of how we got to where we are today: left to navigate an opaque, fragmented system of uncertain quality in which health coverage is determined by where one works, or how old or poor one is, with scant regard for individual preferences. Historical accident even plays a role. As far back as 1916, "national" social insurance along German lines was seriously considered in America, but the Great War put a stop to any notion of using Germany as a model.

In lieu of government action, modern American health insurance grew out of pre-paid health care offered in the 1930s and '40s by groups such as Kaiser Permanente, the Group Health Cooperative of Puget Sound, and the Ross-Loos



Clinic in Los Angeles. Although FDR was not able to get Medicare into the Social Security Act of 1935, the federal government soon became involved in health care via the Hill-Burton Act of 1946, which provided federal subsidies for hospital construction. Of course, this led to overbuilding, which politicians thought led in turn to excess demand for health care. So, by the 1960s, states reacted by requiring restrictive "certificates of need" to be issued before the construction of new hospitals!

This kind of action-reaction got even worse when the government started taking over health insurance in the 1960s, launching Medicare for seniors and Medicaid (in collaboration with the states) for poor people. Government health spending quickly spiraled well beyond what had been budgeted. At the same time, technological advances and rising household incomes led to more private health spending. Because health insurance increasingly insulated people from the costs of health care, third-party payers responded by imposing ever more inventive methods of containing costs. None of them worked very well.

And then came the HMO. Today those three letters horrify most Americans, who will be surprised by Dranove's very light judgment upon the bland-sounding health maintenance organization. Favored by legislation in 1974, HMOs expanded from the West Coast and came to dominate the country in the 1990s. During the first Bush presidency, health economist Alain Enthoven proposed a national health system of "managed competition" by HMOs. John H. Sununu, the president's chief of staff, infamously declared that "if the American people want health care, they'll vote for Democrats," an obtuse statement betraying both a tin ear for Americans' health needs, and ignorance of how government intervention was already driving health costs out of control. Regrettably, that's exactly what they did: "managed competition" was also the core of the 1,700-page HillaryCare colossus, of which Enthoven later advocated throwing out all 1,700 pages.

Which brings us to the final days of the second Bush presidency and Dranove's examination of current options for reform. If we categorized health economists like foreign policy experts, Dranove would lead the realist school, mixing cautious optimism with healthy skepticism. He is tempted by the purity of spirit of single-payer, government-monopoly health care, but resists it because of its human costs (long observed in Canada and Britain)—lengthy queues for patient diagnosis and treatment, and unwillingness to invest in medical research and development.

Although he generally believes that HMOs held down health costs without harming quality of care, Dranove acknowledges that the 1990s model was not sustainable: neither patients nor doctors could stand it, and HMOs were losing money by the time their popularity nosedived beyond redemption.

Having tried everything else, we are left with the consumer-directed health plans (CDHPs) favored by President George W. Bush and many Republicans—and welcomed by Dranove with one hand clapping. CDHPs have high deductibles, low premiums, and are connected with a cash account such as a Health Savings Account (HSA). The idea is to give patients control of a significant share of their health care dollars,

in the expectation that they will spend it more carefully than if their care is (almost) free.

While solid research (the RAND Health Insurance Experiment) supports this conclusion, Dranove worries that consumers are not well equipped to determine either prices or quality. He does recognize, however, that various services are filling the information gap, and offers an excellent introduction to the strengths and weaknesses of many current approaches to measuring quality. He also has some first-rate suggestions for fine-tuning CDHP co-payments and deductibles so that patients with chronic illnesses (e.g., diabetes) do not face financial disincentives to maintaining their care.

I have only two quibbles with *Code Red*. First, the book confusingly asserts that an HSA-owner must "use it or lose part of it." HSAs, created in 2003, are tax-advantaged accounts held at banks or broker-dealers and are the personal property of the depositors. The previous "use it or lose it" version was a Flexible Spending Arrangement (FSA). Second, Dranove frequently cites the well-known figure of 47 million uninsured, which most laymen misunderstand as the number of permanently uninsured Americans. In fact, the figure encompasses millions who are between jobs (the "frictionally" uninsured), others who are eligible for government health programs but are not enrolled, those who could reasonably afford health insurance but go without, and illegal immigrants.

EVEN IF WE FIX HEALTH CARE DELIVERY, however, we have another problem: government health care is driving America into bankruptcy. This is no secret. Indeed, the law requires that Social Security and Medicare trustees issue a report to this effect every year, to which Congress pays attention for about ten minutes and then goes back to its usual business.

George P. Shultz, a Distinguished Fellow at the Hoover Institution and U.S. secretary of state under President Ronald Reagan, and John B. Shoven, the Charles R. Schwab Professor of Economics at Stanford University and the Wallace R. Hawley Director of the Stanford Institute for Economic Policy Research, would like both Congress and the American people to pay closer attention to the impending fiscal storm. *Putting Our House in Order* is marketed as a "citizen's guide to all points of view" about how to manage the burgeoning unfunded liabilities of Social Security, Medicare, and Medicaid. The Congressional Budget Office (CBO) projects that these entitlement costs could reach 28.5% of GDP by 2050, whereas total federal revenues have never exceeded 21% in the history of the Union.

And it gets worse: state and local governments also have massive unfunded liabilities for their retired public servants' health benefits. Until recently, they have hidden these from taxpayers. The Government Accounting Standards Board (GASB) requires all public employers to have booked these liabilities by the end of 2008. The numbers are staggering. According to the authors, Maryland has an unfunded liability of $20 billion, nearly double its annual general fund budget. New York City's chief actuary has declared that its assumptions are so unrealistic that the official estimates are "meaningless."

Nor is the bleeding confined to the public sector. Many older companies also have defined benefit pension plans (often with retiree health benefits) that are on shaky ground. Although most companies have adopted defined contribution plans such as the 401(k) in the last 25 years, there is still a critical overhang of companies with defined benefit plans. Such plans are the liabilities of the firms rather than the property of the employees.

These schemes are not in good shape: between 2002 and 2005, over 20 companies defaulted on their "pension plans of more than $100 million in size." Although insured by the Pension Benefit Guarantee Corporation (PBGC), the PBGC's premiums have not kept pace with the rate of defaults. The biggest recent pension default resulted from the bankruptcy of United Airlines, which took from 2002 to 2006 to work out. Furthermore, because the PBGC's maximum insured pension is $45,000, pilots who retired with pensions of $100,000 suffered serious cuts in their pension income. Americans might not count retired commercial airline pilots among the suffering, huddled masses of the world, but their loss is symptomatic of a systemic crisis. Indeed, Shultz and Shoven fear that the PBGC might need a taxpayer bailout!

Remarkably and quite happily for their readers, Shultz and Shoven face this perfect fiscal storm with optimism, proposing solutions that restructure pensions without raising taxes. They note that while health care and pension liabilities form an increasing slice of the nation's fiscal pie, we have a number of methods to grow the entire pie (i.e., GDP). One benefit of our expensive, innovative health care is that people are aging better. When Social Security began in 1935, an average 65-year-old man could expect to live 12 more years, and a woman 13. In 2004, life expectancy at age 65 was 16 more years for men and 19 years for women. In fact, male life expectancy at age 65 has increased by one month per year for the last 30 years.

UNFORTUNATELY, A MAJOR DIFFICULTY IN addressing the crisis of unfunded liabilities is that Americans' savings rate is now close to zero, having steadily declined since the 1980s. Shultz and Shoven's most promising recommendations to solve the problem involve increasing older workers' participation in the labor force through public policies that give them an incentive to do so. Indeed, all the extra years of life gained in the last 70 years have been spent in retirement. And these folks are actually "younger" than the previous generation. When observed through the lens of health status, a 78-year-old woman in 2000 was the same age as a 69-year-old woman in 1940.

How can we motivate more seniors to work? Shultz and Shoven's best ideas include abolishing Social Security and Medicare payroll taxes (but not income taxes) for seniors who take employment, eliminating the surtax on Social Security income for seniors who stay on the job, and pushing the eligible age for Social Security past 67 as life expectancy continues to increase. There are plenty of other suggestions throughout the book, and I think they get only one wrong: allowing employed seniors to use Medicare, instead of their employers' private health benefits, as their primary health care payer. Although this would reduce a firm's relative cost of employing a senior, the flipside is that it is relatively more expensive to hire a younger person, thereby risking increased unemployment or decreased wages for that group.

One hopes that this compelling analysis by one of the nation's leading statesmen and an equally gifted scholar will finally cause our politicians to take heed.

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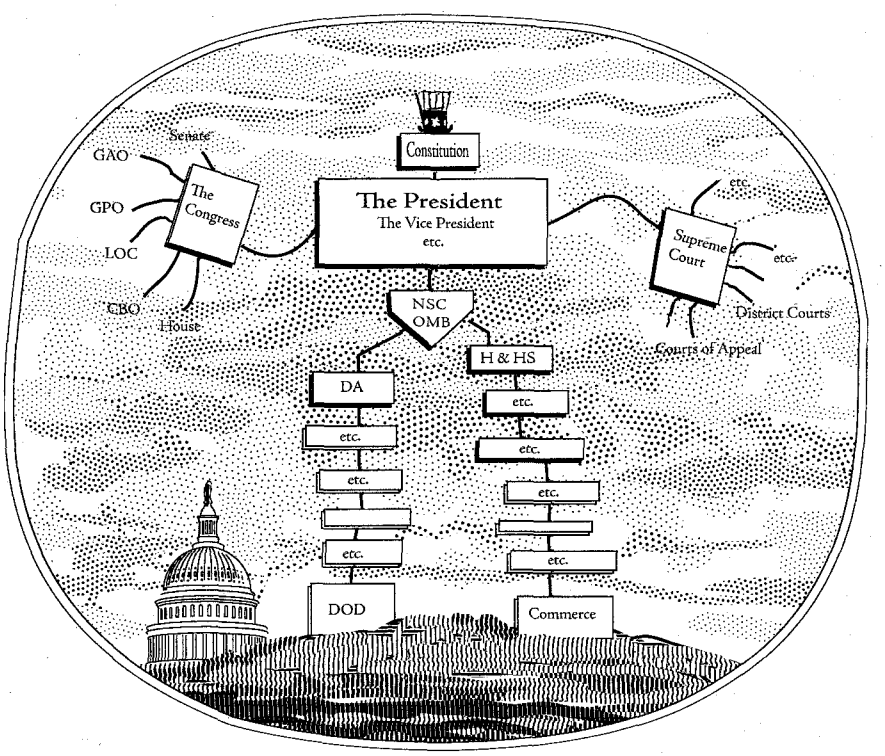
Book Review by Carnes Lord

...And We're Here to Help You

The Warping of Government Work, by John D. Donahue.
Harvard University Press, 224 pages, $35

A Government Ill Executed: The Decline of Federal Service and How to Reverse It,
by Paul C. Light. Harvard University Press, 288 pages, $45



The political landscape in Washington has plainly been profoundly altered by our recent elections. Although it is too early to tell what President Obama's priorities are going to be or how they will align with the preferences of the newly strengthened Democratic majority in the Congress, many things may be possible now in our politics that have not been possible for some time. One of those things is reform of the federal government. Like John F. Kennedy before him, Obama seems to have tapped into a vein of idealism in the American people that could lead to an enthusiasm for government service not seen since the Vietnam War and Watergate. The problem is that government service has over the years become ever more unpleasant and unrewarding.

Especially at a time when business as well as play in America are increasingly shaped by the egalitarianism and self-display of the global electronic environment, the federal government remains a dinosaur of hierarchy, regimentation, routine, and anonymity. Individual achievement is difficult to measure and reward. At the same time, even innocent missteps can land bureaucrats in the newspapers or the courts, wrecking careers and bank balances (consider the case of Scooter Libby). On top of all that, federal salary scales have not kept up with the private sector, particularly in certain key areas. As a result of all these factors, those attracted to federal service are no longer necessarily our best and brightest. Rather, as John D. Donahue argues in a data-filled but readable brief study, *The Warping of Government Work*, federal employment tends to be the preferred option of those seeking what he calls "safe harbor" in government from the rigors of the real economy, with predictably baleful effects on the government's ability to perform its mandated missions.

Donahue, a professor at Harvard's Kennedy School of Government and a former official in the Clinton Administration, takes as his theme the increasing divergence in recent decades between public sector (including state and local government) and private sector employment. In his view, the massive factor behind this divergence is the gradual collapse of the "middle class economy" and the growth of the enormous inequalities in income that we see in the American workforce today. Donahue spends little time bemoaning this development or expecting it to be remedied by government itself, and his bottom line will surprise some. "Government work offers a haven from the roiling turbulence of today's economy for many millions of workers," he writes. "It is eminently understandable that these Americans cherish and cling to a separate working world that still lets them earn a middle-class living. The problem, of course, is that this is not what government is for."

The real economy's distorting effect on government work is twofold. Toward the lower end of the pay scale, due largely to the growing power of public sector unions, workers are generally more secure and better paid than in comparable jobs in the private sector, yet have few incentives to excel—or fear dismissal. At the same time, because salaries for top managers and professionals are artificially suppressed by being linked closely to congressional pay, they discourage retention of the most accomplished and ambitious. (With a few exceptions, executive branch salaries are capped at around $155,000, although annual performance bonuses are also routinely given.) Donahue argues that dysfunc-