Same Surgery, Different Cost: Insurance Explained

October 20, 2009

Princeton economist Uwe Reinhardt argues that health care should be looked at from an unemotional, economic perspective. Reinhardt explains the practice of price discrimination, the process by which the cost of care is negotiated between hospitals and insurance companies.

ARI SHAPIRO, host:

This is TALK OF THE NATION. I'm Ari Shapiro in Washington. Neal Conan is away.

If you need an MRI, for example, one hospital might charge your insurance company $2,500. At a hospital just across town, the same procedure could cost $1,000 less. This hour, we will explain that cost chasm and how a health care bill in Congress might try to fix the problem.

Our guest is Uwe Reinhardt. He’s an economist at Princeton, and he argues that Americans should stop complaining about health care and look at it from a less emotional, economic perspective. He argues that’s the best way to assess what’s wrong with the system and figure out how the country could bring health care costs down.

On Thursday, we’ll hear a different perspective on how we should pay for health care, but first, if you’re in the medical profession or the health care industry, we want to hear from you. In your opinion, what’s wrong with the economics of health care in this country today?

Our number here in Washington is 1-800-989-8255. Our email address is talk@npr.org, and you can also join the conversation on our Web site. Go to npr.org and click on TALK OF THE NATION.

Later this hour, Peter Bergen will join us to talk about drone attacks in Pakistan, whether they’re legal, whether they work and why they’re increasing - but first, health insurance. Joining us now from a studio on the Princeton University campus is Uwe Reinhardt, a professor of political economy at the Woodrow Wilson School at Princeton. He specializes in health care policy, and Dr. Reinhardt, welcome back to TALK OF THE NATION.

Dr. UWE REINHARDT (Professor of Political Economy, Woodrow Wilson School, Princeton university): Oh, thanks for having me.

SHAPIRO: So let's start with the question that I opened with. Why does a procedure like an MRI or a colonoscopy - or anything else for that matter - cost thousands of dollars difference from one hospital to another within the same city, perhaps?

Dr. REINHARDT: Well, there are two reasons. The first one is that one hospital may have different costs than the other one, and hospitals are generally not very much accountable for their costs because there’s no transparency. No one really has any idea what the hospital spends on. In fact, for most nonprofit hospitals, they don’t even have their annual report on their Web site as a for-
profit hospital would have to have. So that's one reason.

SHAPIRO: Hmm.

Dr. REINHARDT: But the other reason is that there is, what we economists call, price discrimination, which means different payers are charged different prices for the same thing.

SHAPIRO: Why would that be?

Dr. REINHARDT: You will - well, you always have that when you have an industry that has very high, fixed overhead costs, but actually producing another unit is not that expensive in terms of the variable costs of making that unit. And then there's always the temptation for some big buyers to say look, I'll pay you more than it actually costs to produce that extra unit of output, but I won't cover all your overhead, and that is - hotels do this. Airlines do it. You know when you sit next to a passenger on an airline, they paid a different price than you did. And some of them paid far less than it would cost to actually maintain the equipment. And hospitals...

SHAPIRO: So you're saying - sorry, go on.

Dr. REINHARDT: …do the same. Hospitals do the same.

SHAPIRO: So if a hospital has to pay a certain amount to deliver an MRI to a patient, a hospital may charge many times that amount to one patient and far less than that amount to another. How do they decide on who pays what?

Dr. REINHARDT: It depends on the market power. If you face, as a hospital, a huge insurance company, they will bargain for a steep discount. But if you're an uninsured, middle-class individual, you have no market power, and they will charge you often twice the price that would be charged to an insurance company.

SHAPIRO: So if I'm - sorry, so if I'm a massive insurance company, I can say I'm going to bring you 75,000 MRIs this year, you'd better charge me very little for them, whereas if I'm one uninsured person, I've got no bargaining power. Is that what you're saying?

Dr. REINHARDT: That's what it is. The insurance company will say look, we lower the price, but you can make it up on the volume, we bring you big volume, while the individual says I bring you one appendix. That's not a volume. And so they can jack up the price and take what they want from you.

SHAPIRO: Well, that doesn't seem very fair to either the uninsured individual or the person who's part of a small insurance company, I suppose.

Dr. REINHARDT: No, fairness has nothing to do with it.

(Soundbite of laughter)

Dr. REINHARDT: Markets are not fair in general. I mean, that's the first thing you teach a freshman. Markets do a lot of things, but fairness isn't one of them.

SHAPIRO: So as we look at how best to reform the health care system, should fairness be the goal?
Dr. REINHARDT: Well, I mean, I can't tell what Americans should want, but I always hear them whine in the news media, on the radio and TV that there is unfairness in the system. Most other nations have what is called all-payer system, where there is a uniform fee schedule that every hospital and every doctor gets paid on. And you don’t have this price discrimination that we have. They don’t run their health systems the way we run airlines. But in America, for some reason, we chose this system, and then we go around the world and say we have the best health system in the world and then go home and complain about it all the time. And this is what I would tell my fellow Americans: Why don't you decide what you want your health system to be and then have the courage and the vision to implement what needs to be done to get this done, and an all-payer system would be such a thing.

SHAPIRO: So in these systems you talk about, where someone has decided that an MRI costs a certain amount of money, who makes that decision? How is that number determined?

Dr. REINHARDT: Well, we have, fortunately, a model in the U.S.: the state of Maryland. They have a commission that has a staff, a research staff, and they figure out what an MRI should cost. For example, how would an economist think about it? We would say, well, what is the price of that equipment, how long do you think is its use-life, maybe five years, and then say if you use that machine 80 percent of the time and consider all the additional costs, the personnel and so on, how much would I have to pay you per MRI scan for you to be able to pay off this equipment? That is a knowable number. And then the commission would say this is what we pay you, $700. But in fact, now whatever they can get away with, they will charge you.

SHAPIRO: Is that kind of a national commission that you're describing, something that Congress is considering?

Dr. REINHARDT: It could be what this national commission would be mandated to do. Of course, there was immediately a great brouhaha among hospitals, among insurers and everyone else who has money and power in this country - was complaining about it, but yes, that's what it would be. And Maryland has worked that way for 20 years, and it's done well. It's fair and could be copied.

SHAPIRO: Well, let's go...

Dr. REINHARDT: But it's a matter of political will, really.

SHAPIRO: We're talking with Uwe Reinhardt, who is an economist at Princeton, about the costs of the health care system, and let's go to a caller. This is Mark(ph) in Fall River, Massachusetts. Hi, Mark.

MARK (Caller): Hi, how you doing?

SHAPIRO: Good, thanks. Go ahead.

MARK: Well, I'm an internist, and it's nice to hear that we can set costs on things economically that come from machinery and capital equipment, but my problem is how do you pay those people for their cognitive skills, that are quite complex, such as what an internist does when we see a patient?

SHAPIRO: And are you in the medical system yourself?

MARK: Yeah, I'm a practicing internal medicine physician.

SHAPIRO: Well, Dr. Reinhardt, how do you respond to that?
Dr. REINHARDT: Well, actually, I was on the Medicare Payment Advisory Commission, and I always proposed, let's do this: Let's begin by saying what should, on average, well-established, well-trained internists earn per year as a benchmark? And then you say: We know, roughly on average, what internists do. The data exist. And then you can say if they treated only Medicare patients, with this practice profile that you have, how much would you have to pay them for this and that procedure so that they would get this target income of, say, $300,000. I mean, it's the only way you could do that if you were a government. If, of course, you are in a free market, then it's just a matter of negotiating with Aetna and WellPoint, which this physician probably is doing.

SHAPIRO: Thanks for the call, Mark.

MARK: Sure.

SHAPIRO: Dr. Reinhardt, you described the system we have now, in which Aetna and WellPoint and other insurance companies compete, but they're also competing with hospitals to get the best price. Is that system really giving us the most efficient economic model in terms of what these procedures cost?

Dr. REINHARDT: I don't think it does. I really would like someone to explain to me what the social benefit of this price discrimination is, where the uninsured pay the highest prices, and the biggest insurer pays much lower prices, and then Medicare comes along and dictates a price that's even lower. What is the social virtue of this? It isn't fair. We already established that. But why would we consider that efficient? Efficiency means that you get, for a given resource, sacrifice, the greatest value for society. Why does anyone think price discrimination does do that?

SHAPIRO: Well, I suppose the problem is while everyone wants the greatest good for society in the abstract, in practice, everyone wants the greatest good for themselves, individually, whether that means not having insurance when you're healthy or getting the best possible coverage when you're not.

Dr. REINHARDT: Yes, that is the human condition, and that is why God created leaders.

(Soundbite of laughter)

Dr. REINHARDT: Leaders are supposed to manage these children, which we all are, and that's why households have parents and children. And in a country, we have children, that's us, who are unreasonable, selfish, unpatriotic, and then we are supposed to have leaders to somehow give us a vision and guide us to be less selfish, and that task has been somewhat neglected.

SHAPIRO: Well, as Congress is working on this, what do you make of the progress they've made so far?

Dr. REINHARDT: I am actually quite impressed, given what they have to deal with, because they have not only on the one hand 300 million children to deal with, but they have on the other hand to deal with some very big gorillas who can determine their political future, and so the balance...

SHAPIRO: You’re talking about the hospitals, the insurance industry...

Dr. REINHARDT: Yes, the big lobbyists. I call them - well, one could sort of say in a way they're like tribal chiefs who have their own insurgent fighters out there fighting only their battle, and they have to deal with this. And then in the midst of all this, to spend some, what six months to come up with something, at least, I really admire Senator Baucus for getting that done.
SHAPIRO: Coming up, we'll have more with Uwe Reinhardt. We'll talk about how he feels about the so-called public option next. And if you're in the medical profession or the health insurance industry, we want to hear from you. We are taking your calls at 1-800-989-8255. You can also send us an email. The address is talk@npr.org. I'm Ari Shapiro, and it's TALK OF THE NATION from NPR News.

(Soundbite of music)

SHAPIRO: This is TALK OF THE NATION. I'm Ari Shapiro in Washington. Everyone seems to want the same thing from health care: great quality at a low price. Making those principles work economically is not easy, as Congress has been learning.

Today, we're talking with Princeton health care economist Uwe Reinhardt about how a new system might work or not. And if you're in the medical profession or the health insurance industry, we want to hear from you. We're taking your calls at 1-800-989-8255. Our email address is talk@npr.org, and you can join the conversation at our Web site. Go to npr.org, and click on TALK OF THE NATION.

And we're going to go to a caller now. This is Kalil(ph) in Denver, Colorado. Hi.

KALIL (Caller): Hi.

SHAPIRO: Go ahead. What's your question?

KALIL: Well, I'm in marketing, in the health care industry. And I've always felt that two main things are at least some of the primary cause of all the trouble, and one is the super-specializations that we have gotten into, which I believe cause overuse of the system because the professionals who are in those super-specializations want to do as many procedures as they can and maybe do not look at the whole patient holistically as much as the, say, family practice and internal medicine doctors do. And the other, of course, is what you're talking about right now, which is the huge discrepancy in what the health care is paid. I know some of the health insurance companies have said it would be unfair to have a single-payer option. But I firmly believe it's very unfair the way it is, where the health payer with the most people under their umbrella, you know, get the lowest cost, where the self, single-pay has to pay the full, actually inflated, cost.

SHAPIRO: Well, Dr. Reinhardt, let's get the answer to that question. Do the numbers reflect this notion that the specialization of medical fields has made us get more procedures than we might need?

Dr. REINHARDT: Well, it's a complicated issue. If you have a specialist who can zero in very quickly on your diagnosis, the correct diagnosis, that's actually an extremely efficient way to run a health system. Of course, the problem is that people like that could have blinders on and not see certain connections. They may focus only on the organ in which they really specialize and not realizing that it's actually a systemic problem that originates elsewhere. So that's the downside.

I'm not aware that there is any evidence, conclusive, that the super-specialists are causing this problem. What causes the problem, of course, that we pay so much more for procedures than we pay for the cognitive skill of the professionals. So if you're an oncologist, traditionally you could make more money on the drugs you bought and administered than you got paid for your skill and intellect. That's what really drives it. It's not specialization as much as the fact that we probably overcompensate the specialist.
SHAPIRO: Okay, well, thanks for the call, Kalil.

KALIL: Thank you very much.

SHAPIRO: You know, Dr. Reinhardt, one of the other things that the caller mentioned was the so-called public option, which President Obama supports, which would create a government-run health care system to compete with some of the private insurance companies. What impact would that have one the cost-pricing system we're talking about?

Dr. REINHARDT: It would very much depend on how you would structure it. If you had a public option available to all Americans under 65 that simply piggybacked on Medicare, used the same claims process, same fee, same everything, that would drastically lower the premium cost. Why? Because you would no longer have to pay marketing. You would no longer have to pay profits, although that's only about three percent to five percent of the premiums. Still, it all adds up. Administration would be cheaper because Medicare is basically a pretty simple insurance program with a common nomenclature, electronic billing and so on. So there would be some savings, but the big savings would undoubtedly be that Medicare gets much lower prices from hospitals and doctors because they can literally dictate them.

So that would make the premium cheaper, and the insurance industry says well, that's really unfair. We cannot compete with a government that dictates prices. And there is, I think, a valid argument to that on the fairness count. If you had such a system, eventually the public system, I think, would attract an awful lot of American patients and diminish the private insurance industry, although there would always be a niche for them, but it wouldn't be as big as now.

So in part, that's an issue of fairness, but then you would have a government-run system whose budget would be pitted against defense and everything else they do.

SHAPIRO: Mm-hmm.

Dr. REINHARDT: And sometimes in these systems, you find that they are underfunded.

SHAPIRO: Yeah, and if, as you say, the real problem here in the difference in cost of procedures from one hospital to another or one insurance company to another is the competition of different-sized insurance companies, then it would seem that having a public insurance company in that marketplace is just one more competitor negotiating prices with hospitals.

Dr. REINHARDT: It's exactly right. You would this one really big gorilla paying less, possibly even less than full cost of the hospital, and others, who have less market power, wouldn't get such discounts and probably pay a hefty markup. Mind you, though, even if something happened, and the government, Medicare and Medicaid just went away, and you just have the private insurance industry, the big gorillas in that industry also have a lot of market power, gets deep discounts of charges, and the small insurers would also have to pay heavy markups on prices. Of course, that's how these markets work. Whoever is weak, they get most of the bills shoved under their nose. That's how it works.

SHAPIRO: Let's take another call. This is Lisa(ph) in Boise, Idaho. Hi, Lisa, go ahead.

LISA (Caller): Hello, good afternoon. Professor Reinhardt touched on two points that I think are really important. I'm a physician. One is transparency, and the other is objectivity. When you talk about the cost of an MRI, you've stopped talking about outcomes measures, and you pay the same for a good MRI as you do for a bad MRI. And so somehow we've lost the connection between
measureable outcome and what we agree to pay for as a society. We do a lot of unnecessary imaging in particular. The other part of that is the objectivity.

When there is the financial interest of a physician or a group, an entity, in particular equipment, it tends to be over-utilized. And there are numerous studies that have documented vast over-utilization of imaging equipment in particular, and those systems tend to be closed and not transparent to the outcomes measures of larger organizations. And I think those things really drive health care, but they don't - or drive health care costs without driving quality. People get the perception that more is better, but they don't get the benefit of judiciously chosen diagnostic (unintelligible)...

SHAPIRO: Thanks for making that point, Lisa. Well, Dr. Uwe Reinhardt of Princeton, what do you think? Where do accountability and transparency factor into all of this?

Dr. REINHARDT: Well, this system is built to be opaque, deliberately. I mean, no...

(Soundbite of laughter)

SHAPIRO: Terrific.

Dr. REINHARDT: Because, I mean, if you are a provider of any sort, being opaque, not revealing your prices, not revealing quality is heaven. I mean, this is how this system - the whole system thrives on lack of transparency. I once called the local hospital just to see would I get a price for a colonoscopy. They wouldn't give it to me. I mean, it's just how it is.

SHAPIRO: Well, how do we get away from that?

Dr. REINHARDT: Well, again, it would take leadership. It would take somebody in government having the courage to tell hospitals and the providers: This won't go. Now, I do believe that we are actually moving heavily in this direction. Whether you're talking to Republicans or Democrats, people are fed up with the lack of transparency of the system. So I would predict within a decade, there will be considerably more transparency, even half a decade. So I think I could tell the caller there's really hope that we will have more information.

When it comes to outcomes, the problem here is not so much transparency per se as the science of measuring outcome, particularly when you have an MRI. Certainly you can tell whether the scan was a good one or a bad one, and ideally, we would like not to pay for the bad one. But then how do you assert in that, a patient goes to the hospital, they scan the patient, and then who would judge whether that was a good or bad scan? If it's within the same hospital, the physician is not going to - the user of it, say a cardiologist, is not going to be likely to tell the insurers, look, this was a bad scan. Don't pay us.

SHAPIRO: Right. Well, we have an email here from Dan(ph) in Tulsa, Oklahoma. And he writes, I live in the poorest part of Tulsa, Oklahoma, and the problem for many African-Americans is not just access to coverage but access to care as well. He writes, we have one hospital and one clinic in our part of town, so even if someone who lives in north Tulsa has coverage, they have to travel a long way for care. So taking what you've said about market power, how do people who live in poor areas get market power to negotiate for more hospitals in our neighborhoods short of being elected mayor?

Dr. REINHARDT: Well, actually market power, you probably won't get because chances are you're
covered by Medicaid, and Medicaid has market power vis-a-vis insurers. But you're prices are so low that very often doctors and hospitals just don't want to accept Medicaid patients. So you are registered nationally as being insured but in fact that card doesn't really get you access to doctors and hospitals.

The same as getting hospitals in your neighborhood, the only way you can do this is through the political process. It used to be called health planning. It was actually President Gerald Ford who passed and signed a law that we should have regional health planning where you couldn't just do what we have now, all the inner-city hospitals moved to the suburbs, on big campuses and became quite luxurious, while the inner city was left with one hospital, and even it was underfunded. We see that throughout New Jersey, by the way. People are moving out of the cities into the suburbs. Chicago is famous for that.

So this is really a political problem. The market will not solve it. The market only goes where the money is. That's the rule. That's what you teach freshmen. In a market system, resources gravitate to where the money is. Money is a magnet that pulls resources with it. The only way to get health care to the poor physically would be to have some kind of political process that plans where resources go.

SHAPIRO: Well, let's go to another caller. We have Sarah(ph) from St. Louis, Missouri, on the line. Hi, Sarah.

SARAH (Caller): Hi. How are you? Thank you for the show. It's wonderful.

SHAPIRO: I'm glad you're enjoying it. Go ahead.

SARAH: I am a general pediatrician in the area and so for full disclosure I'm a salaried physician. I work for a university and I provide primary care for - I don't know the statistics - probably, about half patients with Medicaid and half with private insurance. And one brief point which I know has been made many times so I'll make it very briefly, is just how frustrating it is to me as a physician and as a health care consumer the amount of money and time we spend just in the processing of health care, the paperwork and the phone calls and letters, rather than on health care. I mean it's just tremendous. It's the major portion of our budgets in hospitals and in, you know, universities, rather than actually taking care of people. And that, you know, that's a lot of, to me, wasted time and money.

SHAPIRO: Dr. Reinhardt, what do you think about that?

Dr. REINHARDT: I think she's absolutely right. No country that I know of spends as much on paper-pushing in administration as this country. It really - it is irresponsible. This cannot be defended, and I don't think anyone really would. The - for example, in the private insurance industry, they don't agree on a common nomenclature. There is no common claims form. And therefore billing is a major, major problem here. So you have - I know I have friends who use consultants to do their claims because it's too complicated for them.

And then, you have many physicians have consultants who do their billing, and these consultants are multi, multimillionaires because they have computers that understand the contract - the insurance contract the patient has. And they can cut what is called a clean bill, a bill the insurer cannot reject. And I really feel sorry for physicians who have to deal with maybe 20 different insurance carriers, each with different claims forms, each with different rules.

I read the other day, a radiology group in Florida - they were 47 doctors with 64 billing clerks. Any
other country would openly laugh at you if you said that that is how you manage health care. In fact, I really do wonder what Americans mean when they say we have the best health system in the world. How can that be best?

SHAPIRO: Okay, Sarah, thank you for your call. We appreciate your…

SARAH: Can I ask a quick question?

SHAPIRO: Sure.

SARAH: I just - I'm curious. In terms of discussing sort of the market value of health care and what the market will bear and things like that. I'm just curious, historically, in the United States - I have lived abroad as well - how it was decided that health care - you know, and I'm not a gambling kind of person, so maybe it's just not my personality to understand it. But how was it decided in the United States that health care should be something that we would sort of gamble on financially? I mean, it makes - I may not agree with it, but it makes sense to me if you buy life insurance, you may or may not die. If you buy a car insurance, you may or may not crash your car. But you buy health insurance at best, you're still going to cost the system money. I mean, even if you're a well person, you still need, you know, immunizations, you still need well checks, you still need screening. So it seems to me like, you know, financially it's not a really good thing to bet on something you're always going to cost - it's always going to cost money.

SHAPIRO: Sure. Okay, Dr. Reinhardt, do you have an answer for Sarah there?

Dr. REINHARDT: Well - this is, of course, cultural. In other countries, health care is viewed like elementary and secondary education. It's viewed as social good. People have a right to it. And it's collectively financed through taxes. And for them, it's very easy. There is no gamble here. For us, health care is a personal - health insurance is a personal financial contract. We call it contingent contracts where a private party says, if these and these and these conditions happen, I will pay either a chunk of money to you or I'll pay the doctors and hospitals that treat you for you. And those contracts are extremely hard to write. Even if they were written by rabbis and priests, they would be very, very hard to write and to enforce. And that is why we have these gambles here. Even if you have insurance, the truth is you don't have a clue when you come out of the hospital how much of that will be paid for you out of pocket and how much the insurer pays. That's unheard of in most other countries.

SHAPIRO: You're listening to TALK OF THE NATION from NPR News.

Well, Dr. Reinhardt, before we have to wrap things up, what do you think the chances are that when this entire health care debate in Congress is done, we'll be left with something that satisfies you at any rate?

Dr. REINHARDT: Well, it will satisfy me to this extent: There are many low-income Americans, very hardworking - you and I meet them every day: waitresses, gas station attendants, groundskeepers in factories or universities. Many of them don't have insurance. And they will get insurance under this bill, which I hope will pass. Does it settle everything? No, it settles about a quarter of what we need to do.

SHAPIRO: All right. Uwe Reinhardt is a political economist at the Woodrow Wilson School at Princeton University. He specializes in health care policy. And he joined us today from a studio there on the campus. Dr. Reinhardt, thank you very much.
SHAPIRO: As I said at the top of the show, we'll hear another perspective on the cost of health care in this country at this time on Thursday.

Coming up, they are lethal instruments of war and they are unmanned. Drones are becoming more common and more controversial. We'll talk with analyst Peter Bergen about the range of legal, ethical and strategic issues raised by their use. I'm Ari Shapiro. It's TALK OF THE NATION from NPR News.

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comments

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RK Halley (Kathh) wrote:
I thought this was great information. Let's keep such information rolling. I remember when a hospital wanted longer stays. It took the DRG's to drag them into a mind set of staying out of the bed, during recovery process. Today would a patient really know that MRI is expensive and over used? That waste and over-use needs a parents oversite?
Thu Oct 22 2009 02:38:28 GMT-0400 (Eastern Daylight Time)

Andy Bernaski (AndrewinOakland) wrote:
Question: If Maryland is the model to emulate, why are the costs for medicine in Maryland in the third "quartile" according to this study: http://www.commonwealthfund.org/Charts-and-Maps/State-Scorecard-2009.aspx, which I believe means the cost is above average?
Is the State of Maryland overpricing procedures? Why? Are the insurance companies lobbying (giving money, perks) the legislators to keep the prices up? Something isn't working in Maryland and this needs to be looked into before the federal government gets caught in the same bind.
Gary Laugel (Ishmael) wrote:
Great interview and great caller questions that, in a rare instance, expose the remarkable extent of corruption behind US medical care availability. If anyone had any doubts, this great program might help expel them. What a great expose. Wonderful analogies too: comparing the health-care "gorillas", the lobbyists, to "tribal chiefs" running their own terrorist campaigns against the voices of reason. The opacity of the US system of pricing for health care is absolutely obscene. Incidentally, the adult/children analogy to voters and leaders is particularly apt in a place like the US that is so out of touch with modern realities.
Uwe Reinhart possesses an uncanny, unique and totally accurate view of how to compare US health care with other systems worldwide.
Tue Oct 20 2009 20:59:09 GMT-0400 (Eastern Daylight Time)

Elise Lalor (LariLari) wrote:
I appreciated Mr. Reinhardt's perspective. Thank you for having him on. His vision is not paternalistic, it's very pragmatic. The leaders/constituents, parent/child metaphor was just that. A metaphor. But, personally, with so many people getting their news spoon-fed to them and shirking their duties as citizens, I might have to agree.
Tue Oct 20 2009 18:25:09 GMT-0400 (Eastern Daylight Time)

Stuart MacLean (stumacscs) wrote:
Uwe Reinhardt can't possibly know what an MRI should cost. Only a unfettered free-market, supply-demand framework can. (We've never had one).
Mr. Reinhardt, there is no social virtue to communism, "leaders managing children". I'm stunned he calls himself an 'economist'. He reveals a profound ignorance of freedom/capitalism.
Tue Oct 20 2009 17:54:07 GMT-0400 (Eastern Daylight Time)

gari miller (garilaura) wrote:
grew up with medical care in san francisco. when MRI's became common, they flourished. hospitals, only several miles from each other, each boasted their own machine.
sf general, mt zion hospital, ucsf hospital, pmc hospital, etc
and i do not hear of this overkill in the current discussions.
garilaura
Tue Oct 20 2009 15:52:28 GMT-0400 (Eastern Daylight Time)

Gard Edgerton (Gardo) wrote:
The economist has a point of view that is paternalistic (references to "leaders" and "children", the government determining what someone's time is worth) and appears to prefer central control and fixed prices. He feigns ignorance of the United States' preference for free will and a free market economy which seems odd for someone who is an economist at Princeton. According to him, a board would determine what someone's skills and talent is worth. Perhaps he thinks all businesses should be run this way. I'm sure NPR will provide ample time for an economist with a different point of view.
Tue Oct 20 2009 14:47:02 GMT-0400 (Eastern Daylight Time)
**Eve Oyer (NHLlistener) wrote:**
The reason why the healthcare industry is not a sustainable market model is because the individuals making decisions — the patient and the doctor — have no idea what any of the treatment options cost. Imagine what our grocery cart would look like if there were no prices on the grocery store shelves and someone else paid the bill after we checked out. To make matters worse, the payor (the insurance companies) don't care about the cost, because they simply pass the cost back through to employers who are paying the premiums. Price transparency or consistency is the only way out of this Catch-22.

Tue Oct 20 2009 14:31:04 GMT-0400 (Eastern Daylight Time)

**Patricia Schaniel (Trish101) wrote:**
One of the problems is the politicization of the healthcare issue. Various parties have used scare tactics, calling single payer programs a "government takeover" and "communism" or "socialism." The parties doing the politicization are taking advantage of the public's general lack of understanding of the nuances of the issue.

Tue Oct 20 2009 14:25:28 GMT-0400 (Eastern Daylight Time)