JULY 2022

# A Roadmap for Healthcare Reform in Wisconsin

By Daniel Sem, Ph.D., J.D.
&
Scott Niederjohn, Ph.D.

BADGER INSTITUTE
Free Markets ▪ Opportunity ▪ Prosperity

# A Roadmap for Healthcare Reform in Wisconsin

***By Daniel Sem, Ph.D., J.D. & Scott Niederjohn, Ph.D.***

## Introduction

**The challenge of improving healthcare has gained attention across the nation.** Proposals advanced in Wisconsin and elsewhere seek to reduce healthcare costs, maintain quality and increase accessibility. This report will examine the economics of healthcare, considering both demand and supply in the market. The United States currently does not have an efficiently functioning market for healthcare, and that is especially true in Wisconsin, where even basic direct primary care legislation that was adopted in a majority of states has yet to pass. The reasons for this inefficiency of healthcare delivery will be considered along with the trade-offs that all healthcare public policies must face. Finally, with action unlikely at the federal level to improve healthcare markets, we advance a set of principles that should be followed in any healthcare reforms considered by Wisconsin policymakers. With some of the highest quality healthcare in the country, also ranking second for best doctors (but not as high for health outcomes),[1] Wisconsin can also lead the way in innovating the more efficient delivery of affordable and accessible care.

## The Economics of Healthcare

**Economist Thomas Sowell stated, "The first lesson of economics is scarcity: there is never enough of anything to satisfy all that want it. The first lesson of politics is to disregard the first lesson of economics."**[2] To be sure, healthcare has its peculiarities in both demand and supply. Although analysts commonly refer to a healthcare "market," we will show that the beneficial effects of true markets are often absent. Such forces as third-party payers, pricing problems, counterproductive regulation and a lack of productivity from technology complicate the picture. An underlying problem is the conflation of the terms "healthcare" and "insurance" by politicians. Quality healthcare can be obtained with or without insurance. Further, complete reliance on insurance in its current form removes or distorts typically useful market forces and leads to increased cost. While politicians may talk about "free" healthcare for everyone, a serious consideration of healthcare must begin

with a realistic analysis of the relevant economic principles. We find these to be the most important:

1. *The demand for healthcare has distinctive features that make it different from ordinary consumer demand for goods and services.*
2. *The supply for healthcare faces many obstacles to the efficient provision of service to patients.*
3. *The demand and supply of healthcare do not meet in a well-functioning open market, unlike many other goods and services.*
4. *The exclusive use of insurance to pay for healthcare distorts market forces and gives decision-making power to third parties.*
5. *Therefore, reform should concentrate on ensuring a properly functioning market and improving incentive structures to promote access and affordability while maintaining quality.*

## The Demand for Healthcare

**As the Thomas Sowell quotation indicates, the fundamental problem that all economic systems must grapple with is scarcity.** Healthcare is not immune to trade-offs and economic choices that must be made under such conditions. Resources for the production of healthcare — the people, hospitals, prescription drugs, clinics and technology — have valuable uses in other sectors. What's more, people desire more healthcare than can be provided with existing resources, no matter the funding system employed. As a result, we have to make choices about how, and to whom, healthcare is to be delivered.

Most goods and services produced in our Wisconsin economy come from the private sector, and most people prefer it that way. Few of us would want our cheese, motorcycles or professional sports to be produced by the government. But when it comes to healthcare, people often think differently. To many, the allocation of medical care on the basis of price seems unethical. As a result, many nations with market economies (Canada, the United Kingdom and nearly all of the nations of Western Europe) have chosen socialized approaches for medical care to some degree.

While the systems in these countries differ in particular ways, most hospitals are operated by the government and paid for with taxes. Commonly, tax revenues do not keep pace with the quantity of healthcare that people demand when it is provided for them at no direct cost. Frequently, the result is shortages. To deal with the shortages, governments develop rules and policies to allocate healthcare services. The consequence is that patients sometimes must wait in line for important medical procedures or that certain procedures or drugs are not covered. In Canada, a recent survey[3] revealed that total waiting time between referral from a general practitioner and treatment by a specialist averaged 25.6 weeks. Of that time, the wait from referral to consultation with the specialist was 11.1 weeks. The waiting time between specialist consultation and treatment was 14.5 weeks. The wait times measured for 2020 were all higher than in 2019. They differed substantially across the provinces.

Shortages and other problems in the healthcare sector arise from the workings of demand

and supply — but not always in the same way as in other sectors. One seemingly important difference in demand is the idea that healthcare is a necessity. To be sure, there are not good substitutes for medical care. When healthcare prices increase, the quantity demanded falls very little. For example, when prices increase for the latest cancer treatment or the newest diagnostic device, people still seek the treatment. They are made even more willing because they often do not bear all of the out-of-pocket costs. The economic term for a good or service that sees little change in quantity demanded when the price goes up is "inelastic," and most healthcare demand is decidedly inelastic.

How important is this characteristic of healthcare? Its status as a necessity might seem to set healthcare apart in a special category. However, its necessity does not explain why healthcare should be different. It is understandable to pay a high price for a cancer drug ($170,000 in some cases), but what if the efficacy of the drug is questionable and data suggests it may extend life at most 10 weeks? This is the case for many new and expensive cancer drugs.[4] This clearly presents a moral and ethical dilemma, but does it not include elements of market considerations — and isn't it more logical that the patient rather than a remote third party should make these decisions?

**Healthcare is by no means the only necessity about which consumers make choices.** Food and housing are necessities, too, but most Americans don't turn to others to manage their purchase of food and housing. They don't ask employers to buy their groceries or pay their rent. Their food and housing choices may be supported by nutrition programs or housing subsidies, but they do not expect massive government intervention into these markets.

**Food and housing are necessities, too, but most Americans don't turn to others to manage their purchase of food and housing. They don't ask employers to buy their groceries or pay their rent.**

In addition to being inelastic, the demand for healthcare is highly dependent on income. As incomes rise, people demand more healthcare — and the effect is not small. Per capita income in the U.S. was $63,416 in 2020. That level explains in good measure why Americans now demand more and better healthcare. Economists call goods with a positive response to income "normal goods," and healthcare is a prime example.

The expressed demand for healthcare in the U.S. is boosted by payment methods. American consumers of healthcare depend heavily on third-party payers. Most families have health insurance paid for, at least in part, by an employer. As a result, they do not feel the "bite," in direct costs, of the healthcare they consume. As Milton Friedman once wrote, "Nobody spends somebody else's money as wisely as he spends his own."[5] Vernon Smith, 2002 Nobel Laureate in Economics, described it this way [6]

> *A is the customer, B is the service provider. B informs A what A should buy from B, and a third entity, C, pays for it from a common pool of funds. Stated this way, the problem has no known economic solution because there is no equilibrium. There is no automatic balance between willingness to pay by the consumer and willingness to accept by the producer that constrains and limits the choices of each.*

**For good reasons, consumers of healthcare do not shop around for medical care as they do for other goods and services.** Of course, in an emergency situation, a patient will not and cannot be expected to "shop." But most healthcare is not delivered in an emergency situation. Instead, health services involve repeated interactions between physicians and patients, especially for managing chronic conditions.

Although the relationships are highly personal, neither the patient nor the physician decides what service or therapy can be provided and paid for. Rather, the third-party insurer does, in that the physician follows and is constrained by the rules imposed by the third party. Furthermore, because of the personal nature of the relationship, patients do not quickly or easily change providers.

The disinclination to shop is reinforced by the payment system. From the patient perspective, why spend time shopping for a lower price when somebody else is paying the bill? From the physician perspective, why antagonize others in the system by encouraging out-of-network shopping (which the industry refers to as "leakage")? The point is not that more shopping would solve all of healthcare's economic problems but that important forces that make other markets work are absent in healthcare — with little or nothing to take their place. Consumers might prefer a more efficient market in healthcare that also empowers them, but such a market cannot directly be observed, given the way healthcare is paid for today via insurance-based reimbursement.

**Wisconsin could help lead the nation in empowering patient-consumers to seek care in a functioning market with upfront transparent pricing. A high level of quality, accessibility and affordability would be the result.**

**Health insurance itself has a special status in the U.S.** In 2019, it is estimated that 92.6% of Wisconsin residents had health insurance for the entire year,[7] and 60.5% of state residents had health insurance through their employers. The insurance is part of their compensation packages. It is a form of compensation not subject to federal income tax or Social Security tax. This special tax status makes group health insurance an attractive option for employers and employees, even as it discourages well-functioning markets in healthcare.

It hasn't always been this way. Before World War II, health insurance was an individual responsibility and healthcare costs were much lower. During the war, although workers were in short supply, federal wage and price controls prevented companies from offering increased wages to attract workers. But employers could offer "fringe benefits." One such inducement was health insurance, which benefited from a War Labor Board decision to exempt pension and insurance contributions from wage and price controls.

In 1943, the Internal Revenue Service ruled that such benefits were not to be considered taxable income. The ruling was built into the tax code in 1954, making a temporary wartime expedient into a durable part of the nation's laws. The U.S. is unusual in having this arrangement; Japan is the only other developed nation to rely on a system of employer-provided health insurance. This coupling of health insurance with employment has

been cited as a potential barrier to business creation as workers experience an "entrepreneurship lock," staying in current jobs to keep health benefits for their families.[8]

**Two additional factors influence demand for healthcare:**

- The nation's population is aging, and older people demand more healthcare than younger people. By 2030, over 20% of the population (about 70 million U.S. citizens) will be age 65 or older, and about 8.5 million will be older than 85. People older than 85 are the fastest-growing age group in the U.S. Individuals in this age group consume a great deal of healthcare. They are the ones most likely to be disabled, to use multiple medications and to need comprehensive long-term care.

- Physicians themselves influence demand. Most physicians are compensated on a fee-for-service basis. This provides an incentive for them to offer more services, especially when they know that the services will generate little or no out-of-pocket expense to their patients. The threat of malpractice suits is also relevant. It provides an incentive for physicians to practice what's called "defensive medicine." Failure to test for a potentially serious condition could create malpractice liability, while ordering low-value tests would have no downside for the physician (and would generate additional revenue). In the face of such incentives, it is not surprising that physicians may order expensive tests even when they know the tests have little value medically.

## The Supply of Healthcare

**Like demand, the supply of healthcare has some distinct influences that affect the provision of services.** One such influence is the supply of physicians. Medical education ordinarily requires four years of undergraduate college work, four years of medical school, a residency and perhaps three more years of training in a medical specialty. It is an expensive undertaking in both financial and opportunity costs.

The supply of primary care physicians, informally known as family doctors, is a particular challenge. In a properly functioning market, arguably most healthcare would be provided by primary care physicians. These providers can offer more time with patients and coordination with specialists when necessary. However, primary care is not emphasized in today's reimbursement-driven, fee-for-service model. Driven by insurance, the system is distorted toward care delivery from more profitable specialty care units. Though troublesome, this may not be permanent. A recent Bloomberg article noted how outside the scope of the large providers, this trend in relative importance of physician roles may be reversing.[9]

In most sectors of the economy, supply is increased through gains in productivity. Unfortunately, the healthcare sector has not experienced the productivity gains that are widespread elsewhere in the economy. Healthcare is part of a broader service sector, including teaching, acting and waiting tables. And, like other parts of the service sector, it lags in measured productivity. While today's farmers can grow 20 times the amount of corn of a

1900 farmer because of productivity advances like tractors and pesticides, a brain surgeon today certainly cannot treat 20 times the number of patients she did in 1900.

**Another supply problem is that technology in healthcare works differently than it does elsewhere.** In other sectors, when a technological breakthrough brings new products, the initial price tends to be high. Mobile phones and large-screen televisions, for example, appeared in stores initially as relatively expensive products. In most sectors, however, market forces soon take over and work to reduce prices. High early prices attract additional producers. Competition increases. Production techniques improve. Supply increases, and prices come down.

In healthcare, new technologies often take years to develop, and they are subject to numerous regulations. Their demand may be influenced more by whether they will be covered by insurance than by their medical value. Like other new products, they come onto the market initially at a high price. But we don't typically see market pressures bringing prices down quickly in healthcare (with the possible exception of the switch to generic drugs after patents expire, if in fact they get prescribed). Why not? The explanation has to do with the nature of healthcare when stakes are high. Consumers facing serious medical problems demand prompt access to the latest technology — the latest robot-assisted surgery, the least invasive treatment for a herniated disk or the newest cancer treatment.

Consider the recent and dramatic increase in cost of the EpiPen, an auto-injector that treats allergic reaction emergencies. Per unit, its price abruptly increased several hundred percent. Competition could have easily forced price stabilization, if not for regulatory barriers that make it too time-consuming and costly to introduce a competing product of equal quality and efficacy.[10]

Although competition can stabilize prices, understandably patients and their physicians do not want to wait around for new producers to enter the market, increase competition, increase supply and reduce prices. This preference by patients is made easier, of course, when someone else is paying for the treatment in question.

## Lack of a Functioning Market

**Taken separately, supply and demand for healthcare in the U.S. have their own distinctive problems.** But a more fundamental problem is that, because payments for services are made by a third party (that is, insurance), the demand and supply of healthcare do not meet in a well-functioning open market, unlike many other goods and services. These other sectors have shown that markets do not have to function perfectly to deliver large gains to consumers. Such problems as small numbers of producers and historically poor customer service give way when open competition is possible. But healthcare suffers from being provided outside the context of a vibrant free-market system. Healthcare policies that shift costs heavily to third parties have eroded the incentive for consumers and providers to economize. In the introduction of her 1997 book "Market Driven Healthcare," Regina Herzlinger[11] writes:

> *Is the healthcare sector different from the other sectors of the economy? Are there no lessons at all to be learned from the manufacturing and service industries that turned themselves inside out to give the United States back its number-one competitiveness ranking? Do world-class firms like McDonald's that specialize in quick, courteous, consistent, low-cost service really have nothing that the healthcare sector can emulate? Is there really no role in the healthcare sector for brilliant entrepreneurs and technologies, like those who created the consumer-responsive Home Depot and the technology leader Microsoft?*

Years after the publication of Herzlinger's book, little has changed. Policy discussion tends to focus on how to pay for healthcare's increasing costs rather than how to control those costs while achieving high quality. In a vibrant market, consumers do not have to settle for high costs and indifferent producers. Consumers weigh the price of a good or service against its quality. If the quality isn't provided at the right price, they walk away. Producers pay close attention to these decisions. They innovate to provide consumers with the quality they want at the price they are willing to pay. Providers who are successful remain in business and expand, while providers who are not successful are driven out.

**Would open markets with price transparency work in healthcare? The case of Lasik eye surgery suggests they could.**

An additional obstacle to vibrant markets in healthcare is the lack of price transparency. In most cases, patients undergo a treatment with little idea of how much it costs. In the case of emergency care, until recently there were surprise bills after the fact, averaging $750 to $2,600 per episode.[12] And, given the prevalence of third-party payers, consumers have little incentive to find out prices when they make the "purchase decision" to seek care. However, this issue cannot be completely blamed on lazy healthcare consumers. They find it difficult to compare prices — and the price matters little if insurance is covering the procedure. With prices not easily observable, they can vary greatly across location, insurance status and other factors. A joint replacement can be twice as expensive in one location, but the actual price can be very difficult to observe.[13] Recent federal requirements have added pricing transparency and have reduced surprises, but problems still persist.[14]

Would open markets with price transparency work in healthcare? The case of Lasik eye surgery suggests they could. While not generally covered by insurance, this market has been characterized by innovation, increases in quality, falling prices and even marketing to attract customers based on outcomes and prices. Another example of price transparency is the Surgery Center of Oklahoma,[15] where the prices of procedures are clearly observable on an easy-to-navigate website.

## Healthcare Trade-offs

**Thomas Sowell, once again, provides guidance as we consider the options to improve healthcare funding and delivery in Wisconsin and the nation.** While Sowell was referring to all economic choices when he said, "There are no solutions, only trade-offs,"[16] perhaps no

sector better illustrates this economic law than healthcare.

According to economist Arnold Kling, the trade-offs in healthcare revolve around three primary goals:[17]

- **Access**
- **Affordability**
- **Insulation from risk**

Kling explains that because of scarcity, any system can achieve only two of these three. His "pick any two" framework is sometimes referred to as the "healthcare trilemma." Here, we examine the three goals, including a consideration of quality metrics, and conclude with our recommendations. We believe that reforms should maximize affordability and access while maintaining high quality with measurable positive outcomes. These reforms must involve a greater reliance on market forces. The current opaque and rigid reimbursement-driven world of insurance, we argue, should at least be supplemented and potentially be replaced by market-driven reforms.

***Issues of Access***

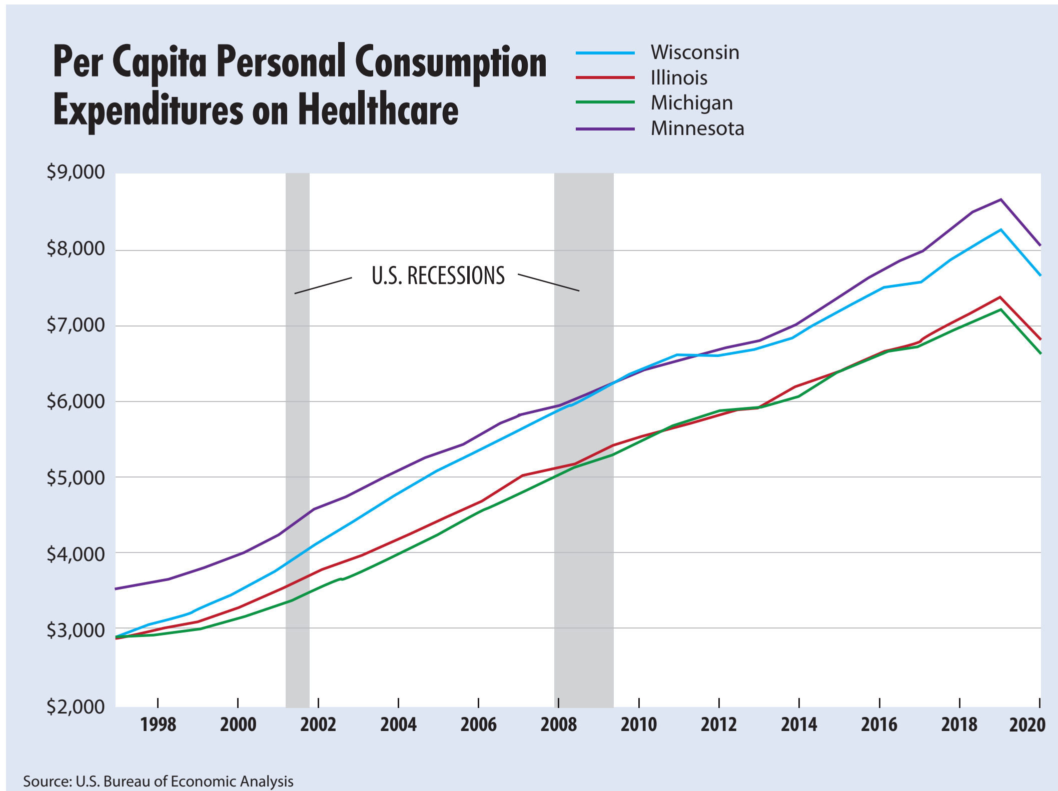
As documented earlier, employers provide most of the healthcare coverage in Wisconsin. The 2019 Wisconsin Family Health Survey reports that 92.6% of Wisconsinites were covered by health insurance for at least part of the year. The report further estimates that 270,000 state residents were insured for only part of the year and 275,000 had no health coverage at all during the year. Among Wisconsin adults age 65 and older, 95% have Medicare coverage and 4% have Medicaid coverage. Compared with whites, 93.7% of whom had health insurance for the entire past year, Blacks stood at 81.2% coverage and Hispanics at 87.1%. Residents in non-poor households averaged 95.8% health insurance coverage last year, while the figure was 86.6% for poor households and 87.6% for near-poor households.

Directly or indirectly, states pick up much of the cost for the uninsured. Uninsured individuals receive healthcare at state-subsidized clinics and hospital emergency rooms. States also bear most of the treatment costs of chronic illness among the uninsured. Moreover, having large numbers of people without good healthcare hurts the state's labor force. It erodes human capital and hampers Wisconsin's productivity.

***Issues of Affordability***

The U.S. leads the developed world in healthcare spending per capita. The Centers for Medicare and Medicaid Services (CMS) estimates that the U.S. spent more than $12,500 per person on healthcare services in 2020.[18] Total healthcare spending in the U.S. consumes nearly 18% of gross domestic product (GDP). In contrast, national health expenditure data collected by the Organization for Economic Cooperation and Development (OECD)[19] reveals that the United Kingdom spent less than $6,000 per person and Canada closer to $7,000.

The chart on the next page shows per capita personal healthcare spending in Wisconsin and other Midwestern states from 1997 to 2020.[20] While each of these states spends less, per capita, than the national average, the total is still nearly $8,000 per person in 2020.




High healthcare spending would be easier to accept if it led to superior health. However, standard measures of health outcomes do not show significant advantages for higher-spending states within the U.S. or for the U.S. relative to the world.[21] This raises the possibility that the U.S. could achieve current levels of health with lower spending, greatly increasing affordability. However, this is only a possibility until reforms are implemented to improve the efficiency of healthcare delivery.

***Mitigating Risk***

Consumers want healthcare to be affordable, but they also want the ability to mitigate risk. That, of course, is the purpose of insurance. "Insurance is a means of protection from financial loss. It is a form of risk management, primarily to hedge against the risk of contingent or uncertain loss," according to Wikipedia.[22] We think of insurance as protecting us against rare but expensive losses, to protect us financially. Insurance protects against "insurable risks," commonly defined as having these characteristics:

- *Potential, rather than already realized*
- *Significant and important in size and scope*
- *Well-defined and out of the policyholders' complete control*
- *Reasonably independent from other losses*
- *Not so large as to be beyond the ability of an insurer to pay*

Defined in this way, individuals' healthcare risks are insurable. Thus, it is not surprising that

health insurance came into its own in the last century as a way of pooling individual risks. In some ways, health insurance is not that different from other forms of insurance. Auto insurance is purchased to pool the risk with other drivers of an accident that leads to very large bills. Homeowner's insurance works similarly. A large pool and efficient administration can keep costs low. Everyone pays a premium and escapes the risk of individual disaster. However, unlike group health insurance, we do not ask our auto and home insurance companies to pay for our routine expenses.

Consider this question: Should auto insurance cover the cost of replacing windshield wiper blades? Most consumers would answer no, recognizing that it's better to handle routine replacement themselves. Adding an insurance company to the mix would only increase costs. Yet even as consumers do not expect insurance to pay for wiper blades, they do generally expect health insurance to cover every medical cost, including some that are small.

**Why spend time shopping for a lower price when somebody else is paying the bill? From the physician perspective, why antagonize others in the system by encouraging out-of-network shopping? Important forces that make other markets work are absent in healthcare.**

**One way to make health insurance more affordable is have consumers handle small costs while keeping insurance in place for the larger, less predictable expenditures.** This is exactly the purpose of high-deductible health insurance plans.[23] These plans provide lower monthly premiums in exchange for larger out-of-pocket costs. High-deductible plans appear unusual to those who are accustomed to the idea that health insurance should cover everything. Yet, covering small medical costs out of pocket was common in the U.S. years ago — and paying for small auto costs instead of using insurance is routinely accepted today. This approach to receiving healthcare was described by David Goldhill in his book "Catastrophic Care."[24]

Is healthcare, defined as the ability to adequately take care of our physical and mental needs and fundamentally about the relationship between a doctor and patient, a right? Many would answer yes. Still, one should not confuse insurance with healthcare. Many Wisconsinites likely view the two terms as synonyms. They are used to treating their health insurance provider as a third-party payer for all of their healthcare needs. Whether one thinks healthcare is a right or not, it is a separate issue when we consider whether universal health insurance should be provided by the government. The government in Singapore provides public healthcare in the form of citizen-owned health savings accounts (HSAs), and the consumers purchase their own healthcare in a private market using these. Thus, they are still using market forces, even though the government feels all citizens should get support for healthcare costs.

Insurance is simply one of many ways of paying for healthcare — a peculiar way that generates perverse incentives and disempowers patient-consumers. It does not just shift the cost of paying, but in a system where prices and market incentives are blunted, it also increases the overall costs of the healthcare system. Incentives for high costs are

spread throughout the system. Consider what happens when a disproportionate share of unhealthy individuals joins an insurance plan. This can occur because individuals with greater healthcare needs, when given the opportunity, are more likely to purchase health insurance. They also may opt for richer benefits than individuals with fewer healthcare needs. In such a case, known as "adverse selection," the insurance plan faces huge claims and must charge high premiums to remain solvent. These high premiums make the insurance even less attractive for relatively healthy people. Their exit makes matters worse and works against the large pools that make insurance more effective.

Any insurance policy or even the entire system can be affected by adverse selection. All of this occurs in a system of insurance that may lead patients to demand, and providers to supply, more healthcare than is medically useful.

***Which Two to Choose?***

Our current health insurance market structure 1) promotes access and 2) mitigates risk. Affordability suffers, as predicted by the Kling trilemma that says we may have only two of the three desirable characteristics. Alternatively, the Canadian and British systems 1) emphasize affordability and 2) mitigate the risk faced by individuals from medical expenses. These two characteristics come from universal healthcare achieved through a single-payer government program. Still, the third characteristic, access, is reduced or compromised. These systems lead to a rationing of care[25] through price controls, spending caps and queuing. The wait times to see a specialist, for example, can be significant. Furthermore, while these single-payer programs decrease direct cost to patient-consumers, the overall cost of healthcare is still relatively high and increasing faster than inflation (albeit not as high as in the U.S.) and paid for in other ways such as taxation.

## Principles for Reform

**We advise that the best mix for Wisconsin is a system that emphasizes affordability and access, while maintaining quality.** To increase the effectiveness of Wisconsin's healthcare system, we believe that policies should incorporate the following principles:

- Consumers should have significant amounts of choice between providers and services. This could be facilitated by ready access to their medical records and flexible usage of HSAs (see below).

- Insurance should be of the high-deductible variety to insulate individuals and families from catastrophic expenses. Both the demand and supply sides of the market would function more efficiently with insurance performing its risk-reduction role rather than being seen as a third-party payer that should cover almost all healthcare expenses.

- Consumers should be able to choose the insurance they want, and it should not be tethered to employment. If there is federal or state-sponsored insurance, there should also be private options available, with tiers of coverage to choose from.

- Policymakers should consider measures to bolster tax advantaged HSAs that could be more flexibly used, such as to pay for routine medical expenses through new compensation models. One such promising model, direct primary care, replaces fee-for-service with a membership fee, resulting in beneficial effects for patients and providers.

- Medicare and Medicaid dollars spent in the state should also be provided via vouchers that may be used to purchase direct primary care, among other alternatives.

- Policy should promote widespread price transparency to allow consumers to make informed decisions about their healthcare. Healthcare navigators or advocates, who have a healthcare and fiduciary duty only to the patient-consumer (rather than an insurance company), could help them navigate the insurance and care options.

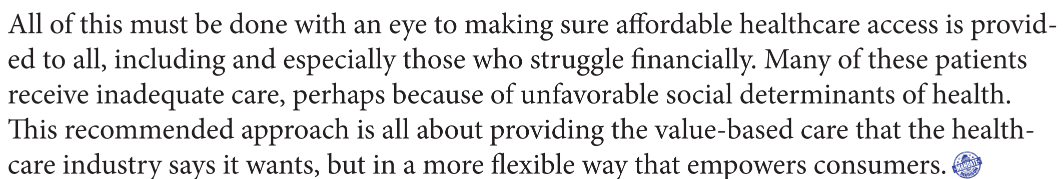
## Conclusion

**Wisconsin could help lead the nation in empowering patient-consumers to seek care in a functioning market with upfront transparent pricing.** We believe that a high level of quality, accessibility and affordability would be the result. Insurance should not be used as the sole mechanism for obtaining healthcare. Patient-consumers, no matter their wealth status, should also have access to healthcare by other delivery channels.

This will be possible in Wisconsin only if consumers have options outside of the traditional bounds and constraints of insurance-driven markets that are not really markets at all. The following elements are necessary:

- *Consumer options to choose quality high-deductible plans (whether private or public)*
- *Protected access to direct primary care providers (physicians, nurse practitioners, etc.)*
- *Freedom to spend Medicare and Medicaid dollars on new models such as direct primary care outside the world of insurance*
- *More flexible usage of HSAs for purchasing healthcare*

All of this must be done with an eye to making sure affordable healthcare access is provided to all, including and especially those who struggle financially. Many of these patients receive inadequate care, perhaps because of unfavorable social determinants of health. This recommended approach is all about providing the value-based care that the healthcare industry says it wants, but in a more flexible way that empowers consumers.



## Endnotes

[1] https://wisconsinexaminer.com/brief/wisconsin-ranks-2nd-among-states-as-best-for-doctors-but-has-fallen-in-healthcare-outcomes/

[2] Sowell, T. (1993). *Is reality optional?: And other essays.* Stanford, Calif: Hoover Institution Press.

[3] Moir, Mackenzie and Barua, Bacchus. "Waiting Your Turn: Wait Times for Healthcare in Canada," Fraser Institute, 2021. https://www.fraserinstitute.org/studies/waiting-your-turn-wait-times-for-health-care-in-canada-2021

[4] https://arstechnica.com/science/2017/02/most-new-high-priced-cancer-drugs-dont-even-extend-life-for-10-weeks/

[5] Quoted by Cogan, John F., Hubbard, Glenn, R. and Kessler, Daniel P. "Healthy, Wealthy and Wise," *The Wall Street Journal,* May 4, 2006.

[6] Smith, Vernon L. "Trust the Customer!" The Wall Street Journal, p. A20, March 8, 2006.

[7] Wisconsin Family Health Survey, 2019: https://www.dhs.wisconsin.gov/publications/p45369a-19.pdf

[8] Fairlie, Robert W., Kapur, Kanika, Gates, Susan M. Rand Corporation research brief: 2011. https://www.rand.org/pubs/research_briefs/RB9579.html

[9] https://www.bloomberg.com/news/features/2022-02-10/primary-care-health-investors-bet-billions-on-medicine-s-worst-paying-specialty

[10] https://www.govinfo.gov/content/pkg/CHRG-114shrg22221/html/CHRG-114shrg22221.htm and https://thehill.com/blogs/pundits-blog/healthcare/292438-competition-is-the-cure-for-epipens-price-hike

[11] Herzlinger, Regina E. *Market-Driven Healthcare*. Reading, MA: Addison-Wesley Publishing Company.

[12] https://www.cms.gov/newsroom/press-releases/hhs-kicks-new-year-new-protections-surprise-medical-bills and https://www.healthcarefinancenews.com/news/surprise-medical-bills-average-750-2600-new-federal-report-says

[13] https://www.healthsystemtracker.org/brief/price-transparency-and-variation-in-u-s-health-services/

[14] https://www.fiercehealthcare.com/hospitals/cms-sent-out-its-first-wave-warnings-to-hospitals-noncompliant-its-new-price-transparency

[15] https://surgerycenterok.com/

[16] Sowell, T. (1987). *A conflict of visions*. New York: W. Morrow.

[17] Crisis of Abundance: Rethinking How We Pay for Healthcare. Arnold Kling. 110 pp. Washington, D.C., Cato Institute, 2006.

[18] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet

[19] https://www.healthsystemtracker.org/chart-collection/health-spending-u-s-compare-countries-2/

[20] U.S. Bureau of Economic Analysis, Per Capita Personal Consumption Expenditures: Services: Healthcare for Wisconsin [WIPCEPCHLTHCARE], retrieved from FRED, Federal Reserve Bank of St. Louis; https://fred.stlouisfed.org/series/WIPCEPCHLTHCARE, February 9, 2022.

[21] https://ourworldindata.org/life-expectancy and https://www.healthsystemtracker.org/chart-collection/u-s-life-expectancy-compare-countries/

[22] https://en.wikipedia.org/wiki/Insurance

[23] https://www.healthcare.gov/glossary/high-deductible-health-plan/

[24] Goldhill, David. (2013) *Catastrophic care: Why everything we think we know about health care is wrong*. New York: Vintage.

[25] For example: https://www.vox.com/2020/1/28/21074386/health-care-rationing-britain-nhs-nice-medicare-for-all

## About the Authors

**Daniel Sem** is vice provost for research and innovation as well as a professor of business and of pharmaceutical sciences at Concordia University Wisconsin in Mequon. He is also president of CU Ventures, CEO of both Bridge to Cures Inc. and Retham Technologies, co-founder and vice president for business development of Estrigenix Therapeutics and director of the Remedium eXchange (Rx) think tank at CUW. He holds a bachelor's degree in chemistry from the University of Wisconsin-Milwaukee, a Ph.D. in biochemistry from UW-Madison and Juris Doctor and Master of Business Administration degrees from Marquette University. He is a Badger Institute visiting fellow.

**Scott Niederjohn** is a professor of economics and director of the Free Enterprise Center at Concordia University Wisconsin in Mequon and a Badger Institute visiting fellow. He has published more than 60 articles, monographs, reports and curriculum materials in journals, is the co-author of two books and serves on the Wisconsin Governor's Council for Financial Literacy. He holds a Ph.D. in economics from the University of Wisconsin-Milwaukee and an MBA with an applied economics concentration from Marquette University.