

# The Obama Administration's Options for Health Care Cost Control: Hope Versus Reality

Theodore Marmor, PhD; Jonathan Oberlander, PhD; and Joseph White, PhD

Controlling the costs of medical care has long been an elusive goal in U.S. health policy. This article examines the options for health care cost control under the Obama administration. The authors argue that the administration's approach to health reform offers some potential for cost control but also embraces many strategies that are not likely to be successful. Lessons the United States can

learn from other countries' experiences in constraining medical care spending are then explored.

*Ann Intern Med.* 2009;150:485-489.

[www.annals.org](http://www.annals.org)

For author affiliations, see end of text.

This article was published at [www.annals.org](http://www.annals.org) on 3 March 2009.

**T**he Obama administration will face no shortage of political obstacles if it boldly pursues comprehensive health reform. Securing a Congressional majority for any large-scale expansion of insurance coverage is a formidable task. Yet, adopting reforms that control costs in American medical care is an even greater challenge.

We address the challenges of cost control in 4 parts. First, we describe pressures for cost control and the impact of the current recession. Second, we discuss the political barriers to adopting effective cost controls in the United States. Third, we examine what the Obama team has advanced as cost-control instruments. Finally, we draw on international experience to offer lessons about what does and does not work in controlling medical spending.

## COST CONTROL AND THE RECESSION

We begin by noting the obviously compelling case for cost control. Increasing costs erode our system of employer-sponsored insurance, swell the ranks of the uninsured, reduce workers' wages, crowd out spending on other social priorities, and strain federal and state budgets for Medicare and Medicaid (1, 2).

The ongoing economic recession exacerbates these problems. Widespread job losses mean that millions of Americans stand to lose health insurance. In this economic climate, employers also face intensified pressures to restrain health care spending and cut back on insurance coverage for those still employed. Meanwhile, rising unemployment levels mean that many more Americans are eligible for Medicaid. States face an acute fiscal dilemma: They must find a way to pay for growing Medicaid enrollment precisely when tax revenues are declining (and balanced-budget rules preclude deficit spending in virtually all states).

In the short term, the federal government is intent on spending more, not less, money on health care. Congress has already expanded health insurance for low-income children through reauthorization of the State Children's Health Insurance Program. It has also adopted additional measures, as part of a broader economic stimulus package, to provide states with more money for Medicaid and to subsidize private health insurance premiums for the newly

unemployed. Another measure makes a large-scale federal investment in health information technology (HIT).

However, pressure to control federal health care spending is likely to build again as a result of exploding federal budget deficits. The Obama administration has pledged to cut the federal budget deficit in half by 2013. Moreover, if Congress and the Obama administration push forward with bolder plans to move the United States toward universal coverage, those plans will have to tackle cost control to meet the financing challenges inherent in expanding insurance coverage.

## THE POLITICS OF COST CONTROL

The United States spends more than any other country on medical care (3). In 2006, U.S. health care spending was \$2.1 trillion, or 16% of our gross domestic product (4). At the same time, more than 45 million Americans lack health insurance and our health outcomes (life expectancy, infant mortality, and mortality amenable to health care) are mediocre compared with other rich democracies. We spend too much for what we get (5, 6).

Nothing is new about these sobering realities. The Nixon administration first declared a health care cost crisis in 1969 (7). Four decades later, the United States still has not adopted systemwide cost controls because the politics of health care make it extraordinarily difficult to control costs. Here, we explain why this is so.

The starting point for understanding the politics of cost control is an axiom of medical economics: A dollar spent on medical care is a dollar of income for someone. In other words, national health expenditures constitute the

See also:

### Print

Editorial comment . . . . . 498  
Related articles . . . . . 490, 493

### Web-Only

Dialogue on health care reform

money that the medical care industry—from physicians, nurses, and hospitals to pharmaceutical companies, insurers, lawyers, and sales and marketing staff—earns. Controlling costs necessarily requires restraining the industry's income (8, 9). As a consequence, serious attempts at cost control produce a battle with stakeholders who have resources, political clout, and strong incentives to oppose measures that reduce the rate of medical spending growth and their income.

The Clinton administration's health reform misadventure during 1993 and 1994 illustrated these political dynamics. The Clinton Health Security plan proposed meaningful cost control, including a de facto budgetary cap on national health spending. That clearly threatened the incomes of many stakeholders and triggered predictably fierce opposition (10).

Since the Clinton plan's demise, U.S. politicians have largely avoided proposing or talking about serious cost control. After 1994, reform efforts at both the federal level (such as the State Children's Health Insurance Program) and state level (such as in Massachusetts) have concentrated on expanding insurance coverage, not restraining costs. The lesson evidently learned from the Clinton experience was that it is extraordinarily risky to take on the medical industry. Although rising costs have helped to push health care reform back onto the agenda during the past decade, it is not surprising that reformers have not pursued serious measures to slow spending.

## THE OBAMA ADMINISTRATION AND COST CONTROL

During the 2008 presidential election, the Obama campaign advanced a number of ideas for cost control that will presumably shape the administration's approach to the issue. These proposals fall into 2 categories: improving medical practice and health outcomes and changing the structure of the health insurance marketplace. We discuss the promise and limits of these strategies.

### Category I: Improving Medical Practices and Health Outcomes

The first category of proposals called for more emphasis on prevention, wider adoption of HIT, better management of chronic diseases, payment reforms that would pay providers on the basis of outcomes, and research on comparative effectiveness to identify preferred diagnostic and treatment options (11).

These reforms—supported by many in the health policy community—are certainly desirable in theory. The United States lags behind many other countries in the implementation of HIT, and the Veterans Health Administration's experience suggests that HIT can contribute to the improvement of medical quality (12, 13). Policies to improve coordination of chronic care and strengthen prevention are always welcome, and the United States might also benefit from the establishment of an independent in-

stitute that informs decisions about medical care utilization and the covering of new technologies (14–16).

However, none of these measures is likely to substantially reduce health care spending in the short run, even if they are worthwhile long-term investments that improve quality of care and health outcomes. The Congressional Budget Office (CBO) issued a report disputing claims of sizable savings from moving to electronic medical records; other CBO studies cast doubt on the capacity of disease management programs to reduce costs (17, 18).

Despite the current enthusiasm for its potential, undertaking comparative effectiveness research alone does not necessarily save money; the savings depend on the uncertain effect such research has on insurers' coverage decisions for medical technologies and on changes in medical practice (19). In other words, although comparative effectiveness research may provide useful information about the clinical effectiveness and costs of medical treatment options, that information is not guaranteed to lead to significant cost savings. A 2008 CBO report estimated that an initiative to fund comparative effectiveness research would reduce national health care spending only “by an estimated \$8 billion over the 2010–2019 period (or by less than one tenth of 1%)” (20).

Similarly, the potential for prevention to generate cost savings is often exaggerated. As health economist Louise Russell documents, “over the past 4 decades, hundreds of studies have shown that prevention usually adds to medical spending” (21). Fewer than 20% of studied preventive options are cost-saving (21, 22). Indeed, preventive measures that emphasize medical services (such as annual doctor visits and screening) rather than behavioral change (exercise and nutrition) can be costly (23, 24). Moreover, changing behavior is not easy. For example, producing behavioral changes that reduce high and increasing obesity rates in the United States (which some analysts argue are a major cause of rising health care spending) is surely desirable (25). It is, however, unclear what public policies could be adopted that would promptly and reliably reduce obesity rates.

It is also unclear whether paying medical providers on the basis of outcomes (pay for performance [P4P]) will generate savings. Pay-for-performance initiatives have generally been designed to improve the quality of medical care, although these efforts have had “lackluster early results” (26). Little investigation of the effect of P4P on medical spending has been conducted to date. However, U.S. P4P programs often aim to increase use of selective medical services (such as preventive screenings), so cost savings are not the primary goal (27). International experience with paying for quality echoes this pattern: A British P4P initiative that aimed to increase spending as well as the use of targeted services overshot its spending targets by a wide margin (28, 29). At this point, we lack evidence that paying providers on the basis of outcomes will reduce spending on medical care.

Debatable claims about cutting costs by improving medical practices and health outcomes create an important additional problem: The Obama administration may have to persuade the CBO to agree with the savings estimates in its health plan to conform with Congressional budget rules. The CBO has taken a skeptical view of the potential of incremental measures, such as electronic medical records and comparative effectiveness research, to control costs. As a result, the Obama administration could be forced to consider more compelling (and controversial) cost-control strategies to finance its health reform plan and get it through the Congressional budget process (30).

### Category II: Restructuring the Health Insurance Marketplace

The Obama campaign also proposed to address increasing costs by restructuring the health insurance marketplace. This approach included the establishment of a new public insurance plan for individuals younger than 65 years. In addition, the Obama campaign called for creating an insurance marketing exchange and adopting new regulations to reduce overhead costs from U.S. insurance arrangements (11).

Insurance regulation can reduce costs (in principle) by limiting the resources that private insurers put into avoiding sales to less healthy customers and charging them much higher premiums. By prohibiting such medical underwriting and by requiring insurers to accept applicants regardless of health status, President Obama's health reform approach could produce some administrative savings. An effective insurance exchange (a new agency that would offer Americans a choice of health insurance plans while also regulating insurers) can lower the high administrative costs that are typical in the current individual and small group insurance markets (31). In addition, the Obama platform proposed more direct limits on insurance overhead. It promised to "force insurers to pay out a reasonable share of their premiums for patient care instead of keeping exorbitant amounts for profits and administration" (11).

The public plan, essentially a voluntary Medicare equivalent for Americans younger than 65 years, could save money in 3 ways. First, it could take advantage of the lower administrative costs of government programs, such as Medicare. Second, the public plan could use its substantial market power to restrain the prices of the medical care it finances. The extent of savings would depend in part on the size of the public plan's enrollment; a larger plan would have more purchasing power to control costs. Savings would, of course, also depend on the political willingness to reduce payments to medical providers. Finally, the combination of marketing regulation and competition from the less expensive public plan could also prompt private insurers to innovate in ways that lowered costs (32, 33).

### LESSONS FROM ABROAD: WHAT WORKS AND WHAT DOES NOT WORK?

In this section, we ask what the United States can learn from international experience with controlling the costs of medical care (34, 35). In fact, the Obama proposals for insurance regulation and a new public insurance option do follow in part from international experience.

All other rich democracies concentrate purchasing power to counter the medical industry's efforts to increase costs (34). If, as in Canada and Sweden, overall medical costs are on public budgets, then officials have powerful incentives to restrain increases in medical costs to avoid reducing the funds for other public programs or having to raise taxes (36). In other countries, such as Germany and France, insurers are nongovernmental entities (sickness funds) that are financed through payroll contributions from employers and employees. The governments of these countries regulate insurers and help them control costs (34). Germany, for example, regulates the level of social insurance contributions (taxes) paid by employers and workers, thereby limiting the budget for all sickness funds.

Lower prices for medical care are the major explanation for the much lower medical costs of all the other rich democracies relative to the United States (37). Competing explanations—that the U.S. population is particularly unhealthy or that Americans use many more medical services—are largely false. In a detailed examination of health care spending patterns, the McKinsey Global Institute concluded that the United States population is "not significantly sicker" than that of Japan, Germany, France, Italy, Spain, or the United Kingdom (3). The McKinsey Global Institute also found that "U.S. patients consume approximately 20% less prescription drugs" in 9 therapeutic areas than do patients in Germany, Canada, or the United Kingdom (3). Furthermore, the average number of hospital days per year in the United States is the second lowest among 12 comparison countries, although American patients receive more inpatient surgeries and imaging services than patients in most peer countries (3). Other studies (38) similarly conclude that "the prices of care, not the amount of care delivered, are the primary difference between the United States and other countries" in health care spending.

International evidence also supports the emphasis on the administrative costs of health insurance. All studies agree that the United States has excess administrative costs that are substantially higher than those of other rich democracies (3, 34, 35, 39). The Obama public insurance option draws on this comparative experience. It avoids the marketing expenses of private insurance and the costs of medical underwriting (the process insurers use to decide whether to offer applicants coverage and to calculate premiums on the basis of health status) (40). In addition, a public plan does not have to generate profits to reward its stockholders.

President Obama's proposal for an insurance exchange

also mirrors international experience with systems in which multiple organizations pay for medical care (often referred to as multipayer systems). Requiring common benefits; similar payment standards; and other simplifying rules, such as prohibiting medical underwriting, can reduce administrative expenses well below those of the United States, as demonstrated by Germany's sickness funds (34). The Obama campaign's planned prohibition of medical underwriting and its adoption of new insurance regulations would move U.S. insurance arrangements closer to the international standard (34).

The Obama team's approach to health reform does not, however, fully embrace the central lesson of international cost-control experience. Effective cost control requires strong government leadership to set targets or caps for spending in the various sectors of medical care (hospital, pharmaceutical, and physicians), either directly or through insurers. The targets may not always be binding, and these caps would be on total expenditures, not services. But without explicit targets and continual efforts to enforce them, no health care system can control costs. That lesson is evident in countries ranging from Canada, Sweden, and the United Kingdom to France, Germany, and Japan (34). In Germany, for example, caps adopted in 1986 had a dramatic effect on spending for physician services.

Some analysts stress other, less reliable lessons about how other countries have controlled costs (41). These arguments often confuse association with cause. For example, other nations do indeed use electronic health records (EHRs) more widely than the United States, but use of EHRs is not why they spend less on medical care. These countries had much better cost control than the United States long before the spread of EHRs (34). No studies have identified different levels of use of health information technology as a primary explanation for why U.S. health care costs exceed those of other nations.

Similarly, the United Kingdom has a National Institute for Health and Clinical Excellence (NICE), and health care costs in the United Kingdom are much lower than in the United States. But these facts are not causally related. The NICE makes recommendations about covering new medical technologies and interventions on the basis of cost-effectiveness principles (and is often cited as a model by American advocates of comparative effectiveness research) (42). However, NICE's main aim has been to rationalize decision making about coverage decisions rather than to constrain spending; it has not operated as an instrument of cost control. Indeed, since NICE's establishment in 1999, spending in the National Health Service has dramatically increased (from 7.2% of gross domestic product in 2000 to 8.4% in 2006) as the British government sought to meet the European Union norm and satisfy long-standing demands for improved, more accessible medical services (43).

In short, if medical costs are to be controlled, no substitute exists for constraining prices and capping expenditures. Frank talk about these cost-control realities, how-

ever, is politically difficult. It immediately elicits alarms from the medical care and insurance industries about "rationing" (ignoring the fact that the United States could realize significant savings from lower prices and administrative costs). Others, particularly the pharmaceutical industry, raise alarms about the effect that cost control would have on the pace of medical innovation. In addition, spending targets constrain medical providers' income and thereby prompt intense political struggles. The Obama team's limited treatment of cost-control realities—including the absence of global budgets and spending targets or caps—seems to reflect a desire to avoid such political controversies.

## CONCLUSION

We write this essay, then, as a cautionary tale. Claims of savings from health information technology, prevention, P4P, and comparative effectiveness research are politically attractive. Their political appeal lies largely in the embrace of widely supported goals, including better health and improved quality of medical care. In theory, these reforms—more research, more preventive screenings, and better organized patient data—sound like benign devices to moderate medical spending. For many purposes, such reforms are substantively very desirable. But these reforms are ineffective as cost-control measures. If the United States is to control health care costs, it will have to follow the lead of other industrialized nations and embrace price restraint, spending targets, and insurance regulation. Such credible cost controls are, in the language of politics, a tough sell because they threaten the medical industry's income. The illusion of painless savings, however, confuses our national debate on health reform and makes the acceptance of cost control's realities all the more difficult.

From Yale University, New Haven, Connecticut; University of North Carolina—Chapel Hill, Chapel Hill, North Carolina; and Case Western Reserve University, Cleveland, Ohio.

**Potential Financial Conflicts of Interest:** None disclosed.

**Requests for Single Reprints:** Jonathan Oberlander, PhD, Department of Social Medicine, UNC School of Medicine, CB#7240, Chapel Hill, NC 27599-7240; e-mail, oberland@med.unc.edu.

Current author addresses are available at [www.annals.org](http://www.annals.org).

## References

1. Nichols L. A Sustainable Health System for All Americans. Washington, DC: New America Foundation; 2007.
2. Bodenheimer T. High and rising health care costs. Part 1: seeking an explanation. *Ann Intern Med.* 2005;142:847-54. [PMID: 15897535]
3. Angrisano C, Farrell D, Kocher B, Laboissiere M, Parker S. Accounting for the Cost of Health Care in the United States. San Francisco: McKinsey Global Institute; 2007. Accessed at [www.mckinsey.com/mgi/tp/healthcare/accounting\\_cost\\_healthcare.asp](http://www.mckinsey.com/mgi/tp/healthcare/accounting_cost_healthcare.asp) on 30 November 2008.
4. Catlin A, Cowan C, Hartman M, Heffler S; National Health Expenditure Accounts Team. National health spending in 2006: a year of change for prescription drugs. *Health Aff (Millwood).* 2008;27:14-29. [PMID: 18180476]

5. **Nolte E, McKee CM.** Measuring the health of nations: updating an earlier analysis. *Health Aff (Millwood)*. 2008;27:58-71. [PMID: 18180480]
6. **Anderson GF, Frogner BK.** Health spending in OECD countries: obtaining value per dollar. *Health Aff (Millwood)*. 2008;27:1718-27. [PMID: 18997231]
7. **Starr P.** *The Social Transformation of American Medicine*. New York: Basic Books; 1982.
8. **Marmor TR.** *Political Analysis and American Medical Care*. New York: Cambridge Univ Pr; 1983.
9. **Evans RG.** *Strained Mercy: The Economics of Canadian Health Care*. Toronto: Butterworths; 1984.
10. **Johnson H, Broder DS.** *The System: The American Way of Politics at the Breaking Point*. Boston: Little, Brown; 1996.
11. Barack Obama and Joe Biden's Plan to Lower Health Care Costs and Ensure Affordable, Accessible Health Care Coverage for All. 2008. Accessed at [www.barackobama.com/pdf/issues/HealthCareFullPlan.pdf](http://www.barackobama.com/pdf/issues/HealthCareFullPlan.pdf) on 20 February 2009.
12. **Schoen C, Osborn R, Huynh PT, Doty M, Peugh J, Zapert K.** On the front lines of care: primary care doctors' office systems, experiences, and views in seven countries. *Health Aff (Millwood)*. 2006;25:w555-71. [PMID: 17102164]
13. **Oliver A.** The Veterans Health Administration: an American success story? *Milbank Q*. 2007;85:5-35. [PMID: 17319805]
14. **Wilensky GR.** Developing a center for comparative effectiveness information. *Health Aff (Millwood)*. 2006;25:w572-85. [PMID: 17090555]
15. **Institute of Medicine Roundtable on Evidence-based Medicine.** *Learning what works best: the nation's need for evidence in comparative effectiveness in health care*. Washington, DC: Institute of Medicine; 2007.
16. **American College of Physicians.** Information on cost-effectiveness: an essential product of a national comparative effectiveness program. *Ann Intern Med*. 2008;148:956-61. [PMID: 18483128]
17. **Congressional Budget Office.** *Evidence on the Costs and Benefits of Health Information Technology*. Washington, DC: Congressional Budget Office; 2008.
18. **Congressional Budget Office.** *High-Cost Medicare Beneficiaries*. Washington, DC: Congressional Budget Office; 2005.
19. **Neumann PJ.** *Using Cost-Effectiveness Analysis to Improve Health Care: Opportunities and Barriers*. New York: Oxford Univ Pr; 2005.
20. **Congressional Budget Office.** *Budget options*. Volume 1: Health Care. Washington, DC: Congressional Budget Office; 2008.
21. **Russell LB.** Preventing chronic disease: an important investment, but don't count on cost savings. *Health Aff (Millwood)*. 2009;28:42-5. [PMID: 19124852]
22. **Cohen JT, Neumann PJ, Weinstein MC.** Does preventive care save money? Health economics and the presidential candidates. *N Engl J Med*. 2008;358:661-3. [PMID: 18272889]
23. **Welch HG.** Campaign myth: prevention as cure-all. *New York Times*. 7 October 2008. Accessed at [www.nytimes.com/2008/10/07/health/views/07essa.html?partner=rssnyt&cemc=rss](http://www.nytimes.com/2008/10/07/health/views/07essa.html?partner=rssnyt&cemc=rss) on 20 February 2009.
24. **Russell LB.** *Prevention's Potential for Slowing the Growth of Medical Spending*. Washington, DC: National Coalition on Health Care; 2007.
25. **Thorpe KE, Florence CS, Howard DH, Joski P.** The impact of obesity on rising medical spending. *Health Aff (Millwood)*. 2004;Suppl Web Exclusives:W4-480-6. [PMID: 15496437]
26. **Rosenthal MB.** Beyond pay for performance—emerging models of provider-payment reform. *N Engl J Med*. 2008;359:1197-200. [PMID: 18799554]
27. **Rosenthal MB, Frank RG, Li Z, Epstein AM.** Early experience with pay-for-performance: from concept to practice. *JAMA*. 2005;294:1788-93. [PMID: 16219882]
28. **Doran T, Fullwood C, Gravelle H, Reeves D, Kontopantelis E, Hiroeh U, et al.** Pay-for-performance programs in family practices in the United Kingdom. *N Engl J Med*. 2006;355:375-84. [PMID: 16870916]
29. **Galvin, R.** Pay-for-performance: too much of a good thing? A conversation with Martin Roland. *Health Aff (Millwood)*. 2006;25:w412-19.
30. **Oberlander J.** The politics of paying for health reform: zombies, payroll taxes, and the holy grail. *Health Aff (Millwood)*. 2008;27:w544-55. [PMID: 18940835]
31. **Tollen L, Crane RM, Liu R, Zarkin S.** The nongroup market as one element of a broader coverage-expansion strategy. *Health Aff (Millwood)*. 2002;Suppl Web Exclusives:W383-6. [PMID: 12703598]
32. **Holahan J, Blumberg L.** Can a Public Insurance Plan Increase Competition and Lower the Costs of Health Reform? Washington, DC: Urban Institute Health Policy Center. October 2008. Accessed at [www.urban.org/UploadedPDF/411762\\_public\\_insurance.pdf](http://www.urban.org/UploadedPDF/411762_public_insurance.pdf) on 20 February 2009.
33. **Hacker JS.** *Health care for America: A proposal for guaranteed, affordable health care for all Americans building on Medicare and employment-based insurance*. Briefing Paper 180. Washington, DC: Economic Policy Institute; 2007. Accessed at [www.sharedprosperity.org/bp180/bp180.pdf](http://www.sharedprosperity.org/bp180/bp180.pdf) on 20 February 2009.
34. **White J.** *Competing Solutions: American Health Care Proposals and International Experience*. Washington, DC: Brookings Institution; 1995.
35. **Ginsburg JA, Doherty RB, Ralston JF Jr, Senkeeto N, Cooke M, Cutler C, et al; Public Policy Committee of the American College of Physicians.** Achieving a high-performance health care system with universal access: what the United States can learn from other countries. *Ann Intern Med*. 2008;148:55-75. [PMID: 18056654]
36. **Marmor TR.** *Understanding Health Care Reform*. New Haven: Yale Univ Pr; 1994.
37. **Anderson GF, Reinhardt UE, Hussey PS, Petrosyan V.** It's the prices, stupid: why the United States is so different from other countries. *Health Aff (Millwood)*. 2003;22:89-105. [PMID: 12757275]
38. **Anderson GF, Hussey PS, Frogner BK, Waters HR.** Health spending in the United States and the rest of the industrialized world. *Health Aff (Millwood)*. 2005;24:903-14. [PMID: 16136632]
39. **Ginsburg PB.** *High and Rising Health Care Costs: Demystifying U.S. Health Care Spending*. Princeton: Robert Wood Johnson Foundation; 2008. Accessed at [www.rwjf.org/pr/product.jsp?id=35368](http://www.rwjf.org/pr/product.jsp?id=35368) on 20 February, 2009.
40. **Claxton G.** *How Private Insurance Works: A Primer*. Menlo Park, CA: Kaiser Family Foundation; 2002. Accessed at [www.kff.org/insurance/upload/How-Private-Insurance-Works-A-Primer-Report.pdf](http://www.kff.org/insurance/upload/How-Private-Insurance-Works-A-Primer-Report.pdf) on 20 February 2009.
41. **Davis K.** Slowing the growth of health care costs—learning from international experience. *N Engl J Med*. 2008;359:1751-5. [PMID: 18946060]
42. **Steinbrook R.** Saying no isn't NICE—the travails of Britain's National Institute for Health and Clinical Excellence. *N Engl J Med*. 2008;359:1977-81. [PMID: 18987366]
43. Growth in health spending slows in many OECD countries, according to OECD health data 2008. Paris, France: Organisation for Economic Cooperation and Development; 2008. Accessed at [www.oecd.org/document/27/0,3343,en\\_2649\\_34631\\_40902299\\_1\\_1\\_1\\_37407,00.html](http://www.oecd.org/document/27/0,3343,en_2649_34631_40902299_1_1_1_37407,00.html) on 20 February 2009.

**Current Author Addresses:** Dr. Marmor: Yale School of Management, 135 Prospect Street, Box 208200, New Haven, CT 06520-8200.  
Dr. Oberlander: Department of Social Medicine, UNC School of Medicine, CB#7240, Chapel Hill, NC 27599-7240.

Dr. White: Mather House 113, 11201 Euclid Avenue, Cleveland, OH 44106-7109.