

Hidden Costs Of Health Care

National Public Radio's *Fresh Air*

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1. TERRY GROSS, host:
2. We just heard one story about facing off with a health-insurance company that refused to pay for an illness. To explain why our health insurance system often seems irrational, we invited Uwe Reinhardt, a health care economist who is a professor at Princeton.
3. He'll also give us his analysis of President Obama's health care plan. Reinhardt is a past president of the Association of Health Services Research and served as a commissioner on the Physician Payment Review Committee established by Congress.
4. Uwe Reinhardt, welcome to FRESH AIR. You chaired a commission, and you were appointed by Governor Corzine of New Jersey. So it was a commission to recommend how to make the New Jersey health care system more rational.
5. Dr. UWE REINHARDT (Health Care Economist, Princeton University): Correct.
6. GROSS: And in one of the chapters of the report, you write about the economics and performance of New Jersey hospitals. And in this chapter, you write about how many different prices there are for the same procedure at one hospital. And New Jersey is typical of other states in this matter. Why are there so many different prices for any one given procedure at a hospital?
7. Dr. REINHARDT: Well, every insurer negotiates with every hospital the prices for thousands of different things. And so for a simple procedure like a colonoscopy, one insurer will have 30 different prices, one for each hospital. And then the same hospital might get five different prices from the same insurance company, depending on whether it's an HMO contract, a PPO contract, an indemnity contract and so on.
8. And I was astounded at the range of prices across the state, just this little state, that some hospitals get maybe \$400 for a colonoscopy, and another one might get \$3,000 for a colonoscopy.
9. You asked what drives this. It can't be cost because they cost pretty much the same. It's just bargaining power. That's all it is.
10. GROSS: And then you also write that hospitals attempt to shift costs from one payer to another, or from one service line to another based on relative profitability. So I guess one way of counteracting this kind of wacky array of costs is to shift the cost from one payer to another. What do you mean by that?
11. Dr. REINHARDT: Hospitals will tell you that Medicaid typically pays less than the full cost of servicing Medicaid patients. Similarly, they claim Medicare pays them maybe \$.90 on the dollar of what it costs to serve Medicare patients. And then they say this shortfall from the government payers, we're going to simply add it to the tab of the commercially-insured patients, or the self-paying patients. So we raise their prices. That is what they mean by cost shift.

12. GROSS: Now you've also written about how hospitals have really large staffs of billing clerks just to haggle with insurance companies. What kind of haggling goes on between the billing clerks and the insurance companies?
13. Dr. REINHARDT: Well, the first thing is there is a haggling over the fee schedules that tie a hospital to an insurer. But then you have a procedure, and a patient gets something that may cost \$100,000. You submit the claim, as a hospital, to the insurer.
14. The insurer will now bargain with you and say was this procedure necessary? And they haggle over the bill. I'm on the board of the Duke University Health System, where our bills often can be in the hundreds of thousands. And so haggling over the bill is profitable, obviously, for the insurer and for the Duke.
15. But at Duke, yeah, we combined all the billing departments into one. And at one point, it was 900. We probably streamlined that down maybe to 600, 700 billing clerks. It's a huge operation.
16. GROSS: This is just for their health care system at Duke.
17. Dr. REINHARDT: Yeah. It's just for the health care system and just for the billing. These people push paper. They do not treat patients.
18. GROSS: I think sometimes individual doctors have to spend a lot of time haggling, going to bat for their patients who have been denied reimbursement for a procedure that their doctor thinks is essential.
19. Dr. REINHARDT: I think that's true, and doctors complain about it. Even in an academic health setting, you still have to fight to get something covered or not needing pre-authorization because there isn't time for it and so forth.
20. But doctors very often have to be the ombudsmen for their patients, arguing with the insurance company. There's no question it irritates doctors. The interesting thing is America's doctors are probably the best paid doctors in the world and have a lot of freedom, but they're very unhappy. And one of the unhappiness is this paper-pushing and fighting with insurers and so on. It's not a good system.
21. It's actually, in a way, tragic when a nation spends as much on health care as we do, that in survey after survey, the American people rate their health system quite low by international standards.
22. I mean, we always rank almost near the bottom in terms of patient satisfaction with the system. And my argument is that isn't over our doctors, who are good, and our hospitals, and I think our health care system is actually very customer-friendly. I really don't think it's the delivery system people are complaining about. It's this hassle over how we pay for our health care.
23. I think how we pay for health care makes Americans very unhappy.
24. GROSS: Uwe Reinhardt is a professor of political economy at Princeton University. He'll have more to say about our health care system in the second half of the show.
25. ...
26. I'm Terry Gross back with health care economist, Uwe Reinhardt. He's a professor at Princeton University and has written extensively about the inconsistencies and inequities in our health insurance system. We're going to get his analysis of President Obama's

health care plan. But first, let's pick up where we left off—how patients and their doctors are constantly haggling with insurance companies over coverage for procedures and illnesses.

27. Do insurance companies sometimes intentionally withhold a payment and say, oh no, you're not covered for this procedure, when they know that you are—that they have figured if they tell enough people that they're not covered, some of them will just kind of drop it and let it go, instead of haggling, and then the insurance company will save money?
28. Dr. REINHARDT: Actually, I personally doubt that, because for that to happen, you would have to write this down somehow. Because, ultimately, the people in the front line are fairly poorly paid people who have to implement the policy. So, you would have to have that written down somewhere, and such a paper in the hands of a trail lawyer would be just dynamite. So, I very much doubt that this is really a form of policy that would happen or that the insurance companies would even intend to do that.
29. But there are obviously gray areas. When you write an insurance contract with a private insurer, it's called a so-called contingent contract, meaning, we will pay you if a certain contingency happens, if you get sick. Now, describing that contingency is very, very difficult. You have to understand, these companies have shareholders, and as a management, you're not supposed to throw away shareholders' money.
30. On the other hand, you also have customers and you obviously do want to serve them and serve them properly. But there are these gray areas where there is a question, was this really insured? To give you an example, there was a case in California where a woman had breast cancer and the doctor wanted to do a bone marrow transplant. The insurance company said, no, this is experimental. We're not covering that. That's not in the contract. And they didn't.
31. Well, the lady died. The company was sued. They had a \$90 million settlement. But some years later, research did establish that bone marrow transplants don't work in this instance and what the company did was actually defensible. So there are these gray areas. Yet, it might also have come out the other way that the research, years later, showed this really did work. And then you make the company look like there were evil.
32. People have to understand that it's extremely difficult to right an insurance company with a private and commercial insurer. It's different when you deal with the government. They'll either pay it or they won't, like in Canada.
33. GROSS: Well, as President Obama tries to rewrite some of America's health care policy and how we pay for health care, you say that Americans are really suffering from cognitive dissonance about health care—that they distrust government. They don't want government running the health care system. And they supposedly have faith in markets, but you say they're unwilling to accept the harsh verdicts of the market in health care, like when you're denied payment to reimburse you for a procedure. Talk a little bit more about this cognitive dissonance that you think we suffer from in America.
34. Dr. REINHARDT: Cognitive dissonance, of course, means that you hold two different theories that are in conflict with one another, but they're both in your brain and in your soul. That's what this means. Now, for example, you will have Americans say the government doesn't have the right to tell me to buy health insurance. But the same

Americans would say, if I get hit by a truck, and I lie bleeding in the streets, society owes it to me to send an ambulance, and the emergency room doctors owe it to me to save my life. How could both be true?

35. Even a teenager would blush at something this ridiculous. If you believe society has a duty to save your life when you get hurt, you have a duty to chip into a fund that pays for that.
36. GROSS: The things that you describe as irrational in America's current health care system, can you find these problems in other developed countries?
37. Dr. REINHARDT: No, I don't think so. The typical Canadian, or German or Englishman understands that they have to pay taxes or premiums to be insured because you're all in this together because you also expect society to save your life when you get in trouble. And they understand tit for tat.
38. I remember my own mother giving me a lecture once when she had to wait in Germany two weeks for the neighboring hospital to have a bed. And I said, oh, I can make a phone call and get you in earlier. And she said I was asocial. She says, then some other lady has to step back. How could this be decent?
39. So, here, I felt lectured by my mother, who had this sense of a social solidarity that, yes, we have a good health system, but you also have to sometimes wait or step back to keep this affordable. Americans complain about the cost of their health care, but they have the desire, I want everything my doctor prescribes, whether it's appropriate or not and I want it today. And then they go and look at God and complain about health care costs. This is extremely frustrating.
40. GROSS: My guest is health care economist Uwe Reinhardt. He's a professor at Princeton University.
41. ...
42. GROSS: If you're just joining us, my guest is health care economist Uwe Reinhardt. He's a professor of economics at Princeton University, and he's written extensively about the economics of health care. President Obama is trying to reform health care in the United States. He says his principles are coverage should be universal, affordable, portable and there should be investments in prevention and improved quality of care.
43. So those are his principles, but he says he's going to let Congress write the details of what the system will look like. And I'm wondering if you think there are inherent problems of letting politicians write health care policy, when it comes down to the type of policy determining how insurance will look.
44. Dr. REINHARDT: No, I think that's a smart approach. We had the alternative, the Clintons tried it, where you had a whole bunch of wrongs, 1,000 policy people tucked away somewhere in Washington developing a finished plan where absolutely everything was determined by the White House presenting it to the Congress and saying, please pass this plan. And the Congress laughed and tore it up and threw it in the garbage can. And that was that.
45. And the lesson we learned from that is, since the politicians have to vote on this and appropriate the money, they must have considerable say on how this looks. So the Obama people are extremely smart, laying out the principles and then letting the Congress spec

this out. Now, on the Hill, you can't 535 people write this, obviously. You have leaders, Max Baucus, Senator Baucus took the leadership last summer. He has an exquisite staff of people. They wrote a white paper and the white paper lays out a passable health reform plan.

46. It's very similar to Obama's plan, by the way. But you could take that and start with it and then make amendments as other players, Senator Kennedy, Senator Orrin Hatch. They are people in Congress, in the Senate and the House who have specialized in health care. In the House it would be Congressman Pete Stark, for example. These are really experts. And they, together, I think, could fashion a bill that obeys, roughly, the principle of President Obama.
47. But it's passable, and fundable and so on. So I think that is the approach that should be taken. And fortunately, Senator Baucus has already done most of the homework for that.
48. GROSS: So what do you think about the basic principles of Obama's plan?
49. Dr. REINHARDT: Well, the basic principles are sound, and I think they would be shared. I think they'd be shared by Senator McCain. Everyone wants universal coverage, wants health care to be efficient and affordable, wants preventive care. I don't think Senator McCain would have differed on those broad principles. But if you go to the campaign Web site of then Senator Obama, he was really quite specific, in detail, of how that thing should look.
50. For example, he had proposed a Medicare-like plan for people under 65. Now, in Medicare it's government run, it's permanent, it's portable and so on. And Senator Obama said, I want younger people to have the same right, to have a plan that is portable, that's permanent, it's government run—somebody they'll trust. That will be, of course, extremely controversial to the private insurance industry because they fear that they cannot compete with a public plan—that Americans would gravitate more and more into it and eventually the private insurance industry would die out.
51. So the big battleground in the forthcoming health reform debate will be this idea of having a public plan. And my gut tells me that maybe President Obama will possibly give up on that idea if, in return, the insurance industry comes to the bargaining table and gives him what he wants, which is that any insurer must serve everyone who comes to them and the premiums cannot reflect the health status of the individual applicant for insurance.
52. So there is going to be some fierce horse-trading this summer over this. And my gut tells me the public plan may very well become a victim of it.
53. GROSS: And that in return we would get—you could get health care in spite of any pre-existing condition—that would be irrelevant.
54. Dr. REINHARDT: Yeah. But that only works if you mandate insurance. If I have—we have in New Jersey, for example, what is called pre-existing conditions—this guaranteed issue—if you go to an insurance company, they have to take you, and they must charge all their customers the same rate whether they're sick or healthy. Well, when you have, on top of that, that health insurance is voluntary, then healthy people will not insure and take a chance.
55. And when they get sick they have the right to join the pool without having taken their sickness into account. That system will inexorably lead to the death of the insurance plan.

And in New Jersey it is happening. The private commercial insurance for individuals is so expensive that most people don't take it. So Obama then would have to go and say, okay, like Massachusetts, you must be insured. It's mandatory. And that's what the private insurance industry is saying.

56. If you want what is called community rate, everyone the same premium, then you have to mandate health insurance or this cannot work. And the insurance industry is right on that one. So there's much to do at the bargaining table this summer.
57. GROSS: Do you think that the nature of support for health insurance reform has changed since the Hillary Clinton initiative of the '90s?
58. Dr. REINHARDT: Yes, I think in the '90s when Hillary Clinton came, things were actually still pretty good, and you had the AMA basically opposed to it. The National Association of Manufacturers, they thought they could handle it on their own. The private insurance industry was pretty rambunctious with the Harry and Louise ad. So they all thought if the Clintons just went away, everything would be fine, and they could handle it.
59. No one thinks that now. The private insurance industry knows that it is actually a declining industry unless they get this new book of business from government. So they are not opposed. The hospitals and the physicians are desperate with patients that they serve who cannot pay them because either their deductibles are very high or they don't have insurance. So it's really beginning to hurt the hospital and the physicians. So they are on board.
60. The average American citizen, even if you have a job today and you have health insurance, you are thinking you might not have it tomorrow or next year, and that wasn't true in the '90s. People sort of felt secure. So the whole landscape has changed.
61. GROSS: If the new health care system mandated that everybody had to carry health insurance, what kind of prices are we talking about here? I mean, I know the health care that you get through your job is usually pretty expensive. A lot of people who—particularly people who weren't employed couldn't afford to pay that. So, how, if it's mandated, would people afford to cover themselves?
62. Dr. REINHARDT: Oh yes. And Senator Obama and now President Obama had been very explicit to say there will have to be substantial subsidies to help lower income people buy this product. And, as you know in his speech the other day, he said he'll earmark particular sources of funds, 634 billion, for the next 10 years to provide these subsidies to low income people.
63. Now, if you divide it by 10, that's about 63 billion a year and—or 65 billion a year—and he had, in the campaign, said he would roughly think of 65 billion a year. So one could say he's owning up to the campaign promise with those funds. Whether he'll get them is another issue that depends, of course, on the Congress. But in any event, I do believe he's making a very sincere effort to own up to a promise that he made.
64. My hunch is to get full insurance coverage for everyone in America. The total amount of money the federal government would have to think about is probably more like 120 billion a year today, or maybe for next year—so, double what he would spend. But he never did promise that he'll go to 100 percent insurance coverage as Senator Clinton had promised. He never did promise that.

65. He said we'll make a substantial down payment and sort of covering half would, in my view, be an honorable gesture on this promise. So I think one can be hopeful that something substantial will happen. My own feeling on this would be the easy way to make sure if you're reasonable—would be to have a debate on the following simple question. What percent of a family's discretionary income, that is, income after housing and food and clothing—discretionary income—what percent of that should a family be expected to pay for its own health care?
66. If you look at upper income people like professors at Ivy League colleges, you could say, well, that should be 15 percent. Your income is such that we could expect you to eat at least 15 percent of your discretionary income. If you look at a waitress, you might say, you know, for her or him, that couldn't be more than five percent because their income is so low.
67. But can you see? If we had a debate on what is it that one can reasonably ask fellow Americans to pay for their own health care, you could get somewhere. And I would hope President Obama would steer the debate into something that people can understand, like this particular question.
68. GROSS: My guest is health care economist Uwe Reinhardt. He's a professor at Princeton University.
69. ...
70. GROSS: If you're just joining us, my guest is health care economist Uwe Reinhardt. He's a professor of economics at Princeton University, and he's written extensively about the economics of health care. Do you think if we pass health care reform and the insurance is all in the hand of private insurance, or even if it's a combination of private insurers and government insurance, that there will still be a class system in terms of the quality of health care that you get, depending on the money that you're willing to pay for the insurance plan that you buy?
71. Dr. REINHARDT: I think it'll happen, although, this is not really what Americans in general would like. But it could happen in the following sense, that you will get subsidies from the government that helps you buy a low-cost insurance product, but that insurance product will cover only generic drugs and it'll cover only certain hospitals that are low cost.
72. And if you want to go to another hospital, they might tell you, well, we'll pay you what we would have paid for the cheap hospital, but if you want to go to Columbia Presbyterian, for example, you pay the whole difference out-of-pocket yourself. This is called reference pricing, where the insurer pays for a standard model, but if you want something more superior, you pay the difference out-of-pocket.
73. I could see that come as the American solution to creating a class-based health system, because you could say, well, we'll give you something, but if you want sort of the superior model, you have to pay it out-of-pocket. That would be rationing by income class. My hunch is, at some point, that's what we'll do in this country. But if any politician proposed that now, it would still be politically incorrect.
74. GROSS: Do you think that the direction we're headed in will keep our country as an employer-based insurance system, for the most part?

75. Dr. REINHARDT: I think some of the larger companies will always prefer to offer health insurance on the job because it's a good come on in the labor market. And let's not forget, we now have great unemployment, but the labor force in America is shrinking relative to the number of elderly and children. So we will have a labor shortage in the next few years—not in the next three, four years, but in the next decades.
76. And having—offering health insurance is a good come on in the labor market. The problem with the American approach is you're losing that coverage just when you need it most, which is when you become unemployed, and you don't have any income and you also lose your health insurance. That is a very devilish system. That doesn't happen in Canada.
77. If GM in Canada were to close, the workers would not lose their health insurance. They would lose their income, but not their health insurance. And in America, you lose your job and your income. On top of it, you lose your health insurance. There is no health policy analyst who would ever put in place such a system if we could do it all over again. It's an accident of World War II that we have it.
78. GROSS: Now, you know your way around health care policy, that's for sure. And you know a lot about health care economics. What's a typical problem you faced with getting your health care coverage? Do you have to fight for things that you think should be insured, and then you're told they're not?
79. Dr. REINHARDT: No, fortunately that really hasn't happened. You know, this complexity of claiming for health insurance is so awesome that my wife does it. This goes beyond the capacity of a Ph.D. in Economics. So she does it, and she tells me that claiming for health insurance is far more time intensive and complex than the income tax, which she also does. So she deals with it because my attitude always is, oh, geez, I'm so busy. Why don't we just pay it and not argue?
80. Dr. REINHARDT: But she will argue because she said it's wrong.
81. GROSS: See, that's where they get you, though, right? Like, because they know some people are just not going to take the time.
82. Dr. REINHARDT: Yeah, they won't take the time. Now, if it were a really big bill, I'm sure she—but she fights, even for smaller things, if she thinks it's just wrong, where, you know, a guy like me would say, I know it's wrong, but my time is too busy, I'll just eat it. And I think the insurance industry very often just relies on people like me and say, we'll just eat it.
83. But fortunately we've not been so sick that it's ever been an issue. And then if you work as a class employer like Princeton, professors really have it good. I mean, we don't share the American experience, frankly, given we have tenure and given we, particularly, Ivy League, we have good health insurance.
84. In some way, I personally don't share the agony of the American people. On the other hand, I grew up in a tool shed and I know how good it was that when we were paupers, my family, we had health insurance like everyone else in Germany. I've never forgotten that, and I would like the American people to have what I had, and my mother had, as a kid. So that is why I care. For me, personally, I'm fine.
85. GROSS: Any final thoughts you want to leave us with about the state of the current health care system or what changes you'd like to see made?

86. Dr. REINHARDT: Well, I would tell listeners, stay away from people who try to solve the health care debate with clichés, like, oh, this is socialized medicine and then you don't have to think anymore. Try to actually think through the issues and say, what is your predicament? What kind of country would you want to live in? Do you want to live in a country where someone who loses their job loses their health insurance? Is that what you want?
87. Do you want a system where kids come out of college, and for the next 10 years, they can't get insurance? You want people who have family members struck with cancer to lose their house or their car? I mean, ask yourself what kind of country do you want to live in. And all of these things I mentioned we have now. You lose your insurance with your job. You can lose your house and go bankrupt over a health care bill.
88. No Canadians or Germans ever go bankrupt over medical bills. Why should we in America do that? And get away from the clichés. And, really, this is, my fellow Americans, this really is your last chance. If you don't get health insurance solved this year or the next year, you are in for some really deep trouble.
89. GROSS: Why now or never?
90. Dr. REINHARDT: Because you have a president who really is committed to this and it requires presidential leadership. You also have a Congress whose leaders in health care are really committed to this idea. And we are in a calamity, we're in, possibly, a Depression, we don't know, but it could happen. It's sort of everything comes together and it's a unique opportunity to get this done.
91. We do know that in better times, every time we tried it, the demagogues won. Harry and Louise won and this time Harry and Louise should not win. You shouldn't even listen to them.
92. GROSS: You're referring to the two characters on a commercial back in the '90s opposing the Clinton reform plan?
93. Dr. REINHARDT: Yeah. Yeah. And I think there is a group now gearing up, and I hope that when they oppose whatever President Obama wants to do, they will actually reason with it. One can disagree honorably over many things in health policy, but don't use clichés like socialized insurance. The fact is that for the bottom half of the income distribution in America, social health insurance is the only solution.
94. GROSS: Uwe Reinhardt, thank you so much for talking with us.
95. Dr. REINHARDT: It's been my pleasure and very good questions. Thank you, Terry.
96. GROSS: Uwe Reinhardt is a professor of political economy at Princeton University. You can download podcasts of our show on our Web site, freshair.npr.org.

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Inequality is Unhealthy

Dr. Stephen Bezruchka on How Economic Inequality is Dangerous to our Health

Democracy Now
March 30, 2009

1. **AMY GOODMAN:** As lawmakers continue to debate healthcare proposals, we take a look at how the economic crisis can impact the health of people in this country. I'm joined here in Seattle by Dr. Stephen Bezruchka. He teaches at the University of Washington's School of Public Health. He's written extensively on the impact of societal and economic inequalities on the health of a population. He argues combating inequality might be the best way to ensure improved health.
2. Why is that, Dr. Bezruchka?
3. **DR. STEPHEN BEZRUCHKA:** Basically, when you ask the question, "Do you want health or healthcare?" Americans think that it's healthcare that produces health, when there really is very little evidence for that. What turns out to be really important is the nature of caring and sharing in society. And the best factor that really impacts that is the degree of inequality. Where societies are more unequal, people don't look out for one another, they look out for themselves. Where societies are more equal—and economic equality is the thing that is most important in this—people look after each other, society looks after each other, and pretty well everyone does better. There's almost nothing that is better in a society that tolerates the extreme levels of inequality in the United States. And so, we end up dying younger than people in all the other rich countries, despite spending half the world's healthcare bill.
4. **JUAN GONZALEZ:** And Dr. Bezruchka, do you see any correlation between the growth of economic equality in the United States and the health of the people in general?
5. **BEZRUCHKA:** Yes. We used to be one of the healthiest countries in the world back in the 1950s. And now we are ... about as healthy as Cuba. And we've been strangling Cuba for the last forty years. So, as inequality has grown in this country, our health, though it's been improving, has not improved as fast as it has in all the other rich countries and quite a few poor ones, as well. No expert really doubts that. That is, we die much younger. Even... major government documents point that out. Most Americans, of course, are not aware of that. They don't realize that they push up daisies well before their time.
6. That's the key issue, to make Americans realize that we need to fight for health rather than for healthcare. I've worked clinically as a doctor for thirty-five years. I'm not against providing healthcare services. But we need to understand that that is not what produces health in society. So we need to first make known the fact that we die younger than we should. Then we need to measure our health indicators relative to other countries. And instead of being ...thirtieth in what I call the health Olympics, we should rise up and be in the top ten, perhaps. I mean, we win the most gold medals in most Olympic contests. If we had ... an event for health, we should be close to the top in the health Olympics. And we don't even show up for the final event.
7. **GOODMAN:** Dr. Bezruchka, how does our healthcare system affect this, influence this? And what is the system you think would improve the health of the most powerful country on earth?
8. **BEZRUCHKA:** Well, if we talk about healthcare system, first of all, we have to recognize, healthcare is a very tiny factor in the health of whole populations. And that's a real polemic.
9. What's really important is how we structure early life. Since half of our health as adults is somehow determined between conception and age three, four or five, early life lasts a lifetime. And we are the only rich country that doesn't have mandated paid maternity, paternity leave, as all the other rich countries do. So we neglect early life, and we pay the price with poor health as adults.
10. I think in terms of a healthcare system, a medical care system, I think we should remove the profit motive from it. As long as we have healthcare insurance companies that in 2005 made \$100 billion in profit, it's very hard to tamper with that kind of an industry. However, profiteering is not good for our health. So I would begin by taking profit out of the system and not seeing it as a market phenomenon.

Source: http://www.democracynow.org/2009/3/30/as_recession_deepens_how_is_the