"Health Care and a Free Society"

by Matthew J. Glavin
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Preview: *In this month's* Imprimis, *public policy expert Matthew Glavin examines some of the issues involving the alleged "health care crisis." Most important, he warns that if we choose "managed competition" over genuine free market solutions, we will never be able to turn back—socialized health care will be here to stay.*

Mr. Glavin's remarks were delivered before a Shavano Institute for National Leadershp audience in Atlanta last May.

Health care reform is one of the most complex public policy issues to face this nation since the creation of the social welfare programs of the 1960s. And, like the welfare programs of the sixties, the decisions currently being discussed in Washington will affect not only health care for millions of individual Americans, but the very foundations upon which our free society was built.

Our current health care system has been characterized as "in crisis." What we ought to remember is that it is the *best* in the world. However, there is no denying that there is room for improvement and that there are serious problems that must be addressed. After all, nationwide, health care costs Americans more than $2 billion per day. Health policy experts have considered a variety of reform proposals including the Canadian-style universal, single-payer program. We have studied the "play or pay" system which would have instituted employer mandates. We have tried tinkering with insurance laws to control costs or expand access. And we have even heard about, albeit fleetingly, market-based reforms based on competition and consumer choice. However, many of the proposed cures currently being debated are worse than the disease.

The centerpiece of the Clinton health care proposal is "managed competition." Managed competition is being presented as a compromise that would supposedly preserve many free market aspects of health care, while making the market more accountable to government control. As envisioned under the Clinton proposal, managed competition would establish a system of collective purchasing agents on behalf of employers and individuals. All residents of a state would be enrolled in one of these purchasing cooperatives, either through their employer or individually. The purchasing cooperative would negotiate on behalf of its members with "Accountable Health Partnerships" (now known as insurance companies) for a benefits package. This "Uniform Effective Health Benefits" package would be established by the government as a minimum standard benefits requirement.

Accountable Health Partnerships would be required to charge all citizens the same rate, regardless of age or lifestyle factors. You would be charged the same whether you were 65 years old, smoked three packs of cigarettes and drank a quart of whiskey a day, and weighed 275 pounds or whether you were 25 years old, exercised an hour a day, never smoked or drank, and were in perfect health. You would be charged the same whether you were monogamous and disease-free or whether you had AIDS as a result of drug use or promiscuity. You would not realize any financial benefit because of the lower or higher risk you represent, resulting from your personal decision as to your lifestyle.

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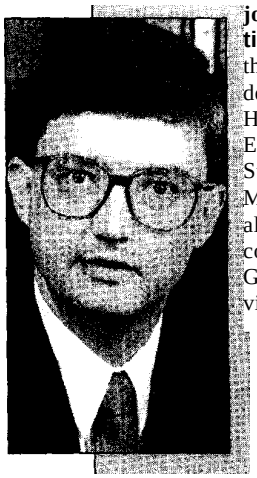

joining the **Foundation, he served as** the **founding** president **of** the **Hannibal** Hamlin Institute for Economic **Policy** Studies in Augusta, Maine. Mr. Glavin is also a political commentator for Georgia Public Television; founder and former president of the State Policy Network, an association of more than 30 free market state think tanks; and a founder of the **Education** Roundtable, a national association of organizations working toward education reform.

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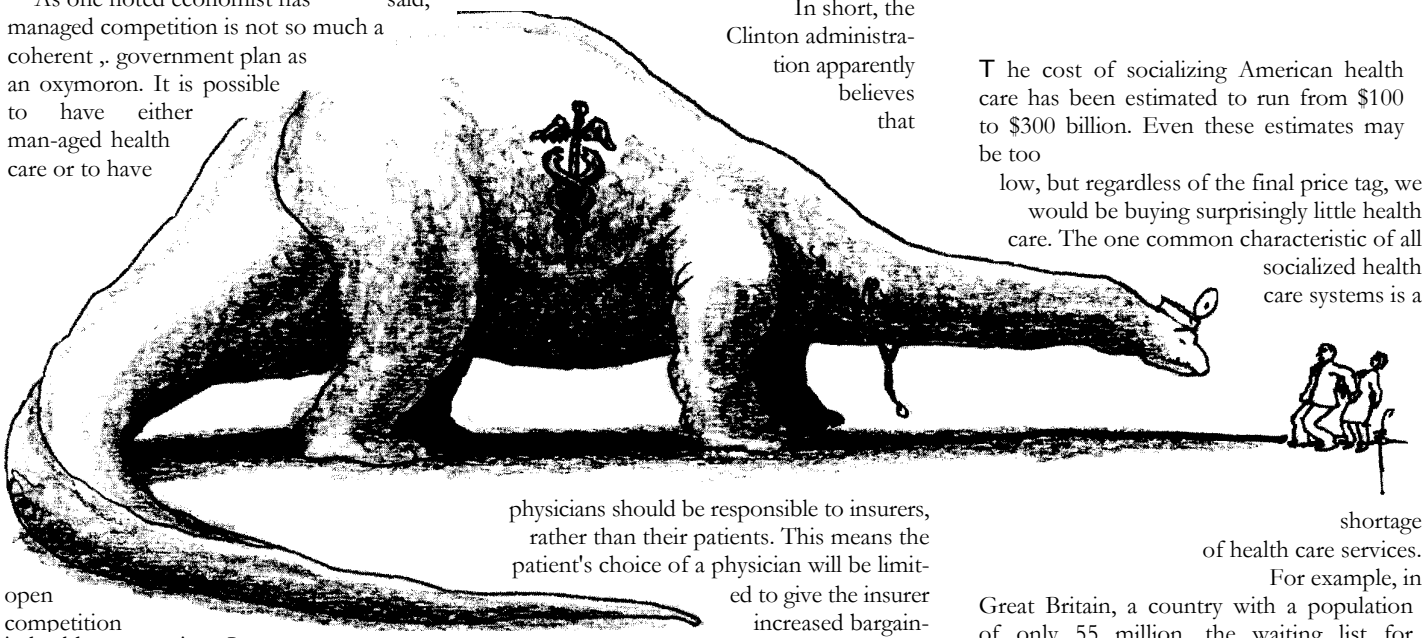
Managed competition also will severely limit consumer choice—choice of insurer, choice of benefits, and choice of physician. Because the Clinton proposal prevents insurers from competing on the basis of their ability to price and manage risk, most traditional insurers would be driven out of the market. The criteria established for Accountable Health Partnerships essentially limit the market to "the Blues"—Blue Cross and Blue Shield—and a handful of large HMOs. The insurance business, now among the top 10 "industries" in the United States, will no longer exist as we know it. The economic impact of this alone will have a devastating effect on the American economy.

As one noted economist has said, managed competition is not so much a coherent ,. government plan as an oxymoron. It is possible to have either man-aged health care or to have open competition in health care services. It is not possible to have both simultaneously. As proposed, managed competition appears to offer a great deal of management and very little competition.



Doctor-Patient Relationship

While our economy may be able to survive the destruction of the insurance industry, an even more insidious problem lies ahead with managed competition. Managed competition holds the potential of severely disrupting the traditional doctor-patient relationship. Because everyone pays the same, regardless of current health status or lifestyle, managed competition changes the historical role of insurers from "financial intermediaries with expertise in underwriting risks" to "health care delivery systems" organizing, managing, and purchasing medical care.

In short, the Clinton administration apparently believes that physicians should be responsible to insurers, rather than their patients. This means the patient's choice of a physician will be limited to give the insurer increased bargaining power with the doctor. It also means increasing insurer control over the physician's choice of treatment, so that insurers can "apply quality assurance or review appropriateness." As Swiss medical philosopher Ernest Truffer has noted, the increasing interjection of third parties between doctor and patient "amounts to a rejection of the medical ethic, which is to care for a patient according to the patient's specific medical requirements, in favor of a veterinary ethic, which consists of caring for the sick animal not in accordance with its specific medical needs, but according to the requirements of its master and owner, the person responsible for meeting any costs incurred." Are Americans willing to reject the medical ethic in our health care system in favor of a veterinary ethic?

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The Cost of National Health Care

The cost of socializing American health care has been estimated to run from $100 to $300 billion. Even these estimates may be too low, but regardless of the final price tag, we would be buying surprisingly little health care. The one common characteristic of all socialized health care systems is a shortage of health care services. For example, in Great Britain, a country with a population of only 55 million, the waiting list for surgery is more than 800,000. In New Zealand, a country with a population of just 3 million, the surgery waiting list now exceeds 50,000. In Canada, citizens must wait nearly 10 months for hip replacement surgery, 2.5 months for a mammogram, and 5 months for a pap smear.

What do these statistics mean in our everyday lives? In January 1990, two-year-old Joel Bondy needed urgent heart surgery. It was a serious operation, but one that was performed many times each day in hospitals across America. Unfortunately, Joel did not live in this country. He lived in Canada, where the country's socialized health care system has resulted in a severe shortage of cardiac care facilities. Canada has only 11 open heart surgery facilities to serve the entire country. The United States, by contrast, has 793.

As a result, Joel's surgery was repeatedly postponed as more critical cases preempted the available facilities. Alarmed at their son's deteriorating condition, Joel's parents

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arranged for him to obtain surgery in

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Detroit. Embarrassed by the media coverage of Joel's situation, Canadian authorities told the Bondys that if they would stay in Canada, Joel would be moved to the top of the list and surgery would be performed immediately. Joel was taken on a four-hour ambulance ride to a hospital equipped for the procedure, but there was no bed available. The family had to spend the night in a hotel. Joel Bondy died the next day.

Sadly, while this is a true story, it is not the exception; it is the rule. Physicians in Canada report that, for heart surgery, you have a better chance of dying on the waiting list than you do of dying on the operating table.

One basic question that has received very little attention throughout the recent debate is whether our government is even capable of providing quality health care at a reason-. able price. For a preview of government-run health care programs, we need only look in our own backyard. Medicare and Medicaid are prime examples of health care delivered via bureaucracy. They are rife with mismanagement, fraud, and abuse. Will the federal government be able to control costs? History would suggest otherwise. Between 1987 and 1992, for example, total Medicaid expenditures rose at ***three times*** the rate of total national health expenditures.

If government is not the solution to our health care "crisis," how do we solve its problems? How do we maintain quality in health care while assuring accessibility and affordability? The only reforms likely to have a significant impact are those that draw on the strength of the free market.

Deregulate Health Care

There should be a thorough examination of the extent to which well intended but mistaken federal and state government policies already are responsible for rising health costs and the unavailability of health care services. I believe that such an examination will prove that government can lower health care costs and expand health care access by taking immediate steps to ***deregulate*** the health care industry, including elimination of state mandated benefits, the repeal of state Certificate-of-Need programs, and the expansion of the scope of practice for non-physician health professionals.

Restructure tax policy

Current tax policy allows employers to purchase health insurance with pre-tax dollars while individuals pay with after-tax dollars. This difference in tax treatment creates a disparity that effectively doubles the cost of health insurance for people who must purchase their own.

For example, the family of a self-employed person who earns $35,000 a year and pays federal, state, and Social Security taxes must earn more than $7,000 to buy a $4,000 health insurance policy. A person working for a small business that offers no health insurance would have to earn more than $8,000 to pay for a $4,000 policy. Tax equalization would add a measure of fairness to current tax policies that penalize the self-employed, part-time workers and employees of small businesses, while subsidizing health care for the most affluent in our society.

Establish Individual Medical Accounts

Individual Medical Accounts (IMAs) are another key to controlling health care costs and strengthening the role of the individual as a health care consumer. An Individual Medical Account would work like this: Individuals would be exempt from taxes on money deposited in an IMA, in the same way they currently pay no taxes on deposits to Individual Retirement Accounts (IRAs). Money to pay medical expenses could be withdrawn without penalty.

The current corporate insurance policy costs about $4,500 per year. With Individual Medical Accounts in place, employers could be expected to change the way they provide insurance. Once a year, a corporation (or an individual, if self-employed) would deposit ***$2,000*** into an employee's IMA. This money, and any interest accrued, would be exempt from taxes. The employer or individual would also purchase a catastrophic health insurance policy that would have a ***$2,000*** deductible. The cost of the catastrophic policy would be about $1,800. The employer who previously provided a $4,500 insurance policy would save $700 a year. Individuals could withdraw money from the IMA without penalty to pay medical expenses. Money left over at the end of the year would accumulate and belong to the individual.

Only about 10 percent of families in this country spend more than ***$2,000*** per year on health care. This means ***90*** percent of all doctor visits would require ***no paperwork*** for insurance because they would be paid directly by the consumer out of the IMA. This also would increase consumer responsibility because there would be an incentive to control costs; the consumer keeps what he doesn't spend.

The use of deductibles in traditional insurance policies right now offers a perverse incentive, particularly for low-income workers. Low-income workers have little discretionary income, and as a result are often forced to forego preventive care or early intervention because they can't afford the deductible. Yet, once the deductible is met, they have no incentive to limit additional expenditures. With an IMA, the incentive is to spend wisely throughout the year.

Individual Medical Accounts would also be completely portable. One of the most serious problems of our current medical system is that insurance is so closely linked with employment. Individuals who lose their jobs or change jobs often lose their health insurance as well. Of the estimated 37 million Americans uninsured at any given time, half are without insurance for four months or less, and only 15 percent are uninsured for more than two years, but it still leaves them vulnerable, if only for a short time. With an IMA, individuals would continue to have funds available to pay for health care during temporary interruptions in employment.

Privatize Medicaid

The current Medicaid system has been one of the greatest failures of American government. Costs are skyrocketing, patients are receiving second-rate care, and providers are being

shortchanged. Actual expenditures for the Medicaid program in 1992 were $124.6 billion. This compares with just $52.1 billion in 1988, meaning expenditures have increased on average 24.4 percent annually over the last four years. The states' share of this joint federal/state program is growing twice as fast as overall state spending. In 1970, Medicaid consumed only four percent of all state spending. Today, the average state spends more than 14 percent of its budget on Medicaid.

As spending increases, states are cutting back on their payments to health care providers. Nearly all states reimburse at a rate well below the actual cost of procedures. The result is that fewer and fewer providers are willing to treat Medicaid patients. Those providers that do treat Medicaid patients often offset losses by passing along the costs to patients with private health insurance, a practice known as cost shifting. The federal government should begin to restructure the system to give Medicaid and Medicare recipients more flexibility to obtain private health insurance that meets their individual needs. As much as possible, responsibility for care of the poor and the elderly should be moved from the public to the private sector.

The average cost per person on Medicaid is more than $3,300 per year. This compares to $1,500 for a privately insured individual. These figures only include direct health care benefits; administrative costs are excluded. For a Medicaid family (a mother and two children) in the United States, we spend almost $10,000 per year in direct medical benefits. The obvious question is: "Why don't we simply privatize Medicaid?" Privatizing Medicaid would create market mechanisms that would achieve all the major goals in health care reform: affordability, accessibility, and quality.

Privatization could be achieved in a variety of ways. Individual states could provide vouchers to Medicaid recipients. The value of each voucher would be equal to the current average Medicaid expenditure for a family of the same size as the recipient's family. Recipients may pool vouchers for the purpose of purchasing group policies. For example, residents of a public housing project may choose to pool their vouchers and purchase a group policy for themselves. Insurance policies purchased with a voucher would include coverage for all federally-mandated Medicaid services. However, all other mandated benefits, including optional Medicaid services, could be exempted. Another option would allow individual states the ability to contract with private insurers (after competitive bidding) for large group policies that would cover Medicaid patients. The state could offer Medicaid patients several private options, including traditional insurance, PPOs, or HMOs.

Regardless of which method is selected, privatizing Medicaid would result in substantial benefits for Medicaid recipients, health care providers, and taxpayers. Medicaid recipients would no longer be treated differently from the privately insured—because they would become part of the privately insured. A Medicaid recipient going to a hospital or physician and presenting his insurance card would be indistinguishable from any other patient. No one would know how that insurance was obtained. And, finally, the patient would have an expanded number of providers to choose from, no longer excluded from the 35 percent of physicians who refuse Medicaid.

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Since reimbursement would be at the same rate as private insurance, health care providers would no longer be shortchanged for treating Medicaid patients. Cost shifting would be eliminated, with a beneficial effect on all health care consumers. Further, by eliminating many of the costly optional benefits and by encouraging insurers to experiment with cost containment, privatization would stop the spiral of increasing Medicaid costs.

Insurers would compete for customers on the basis of the benefits offered, crafting policies to meet the needs of the purchaser. While many of the costly optional benefits no longer would be covered, individuals would be able to purchase a policy that more closely meets their individual requirements. Insurers also would compete on the basis of which cost containment mechanisms they include. Some may offer managed care. Others may offer co-payments and/or deductibles. Still others may offer fewer benefits. Some may even offer "lifestyle incentives" or rebates for nonuse. Everyone would have the freedom to choose the plan that is best for them.

Conclusion

It has long been noted that the Chinese character for "crisis" is the same as the character for "opportunity." If America's health care system is indeed in crisis, as the Clinton administration has alleged, we also have a unique window of opportunity to reform it in a way that will make health care affordable and available to all Americans.

What is outlined here is a series of proposals that tend toward increasing freedom of the market, proposals that draw on the strengths of competition, consumer choice, private ownership, and personal responsibility. The Clinton administration has offered a plan that tends in an exactly opposite direction. It is an about face. The Clinton proposal creates more centralized government control. Government bureaucrats will decide what services you receive. Government bureaucrats will decide how much you will pay. Government bureaucrats will decide what services your doctor can provide. "Competition" will be managed—not competitive. There will be a single source of revenue—the taxpayer.

This is socialism! And, like the social welfare programs of the 1960s, once socialized health care is in place, we will never go back to a market-based system.

All agree that the time for reform is here. But, what decisions will we, as a nation, make? Will we move in the right direction or are we going to make an about face? Will we continue to preserve the heritage of our founding fathers, the principles of a free society, and a market economy based on individual freedom and responsibility, or will we embrace the failed policies of central planning and socialism? Freedom and free enterprise are sweeping the globe. While Europe, Canada, and the former Soviet Union are searching for ways to restore market mechanisms to their socialized health care systems, America is in serious danger of adopting one—a bureaucratic, government-run, taxpayer-financed health care system that will limit patient choice and ration the availability of care, while doing nothing to hold down health care costs.