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America's Health Care Economics: Probing Questions and Second Opinions, Second Edition

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America's Health Care Economics

Probing Questions and Second Opinions

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I. **FROM WOMB TO TOMB**

It has been said, "*There are Seven Ages of Man: spills, drills, thrills, bills, ills, pills and wills."* Fact is, the only way not to die is not to be born. And not being born would certainly take all the pleasure out of not dying--unless, of course, there is a health care crisis in the land.

How in the world can people afford to get the medical care they need, when they need it, and still retain control over their own health care? This is a major medical and economic question.

Christmastime 1993 was not a good time to get sick in Toronto, Canada. There in Toronto, home to one-third of all Canadians, hospitals were closing off many of their wings, emergency rooms, operating facilities, etc. The shutdowns over the holiday weeks were for economic reasons, not for health care reasons. The Canadian system, which had been a model for the efforts of some to reform the U.S. system, was running short of taxpayer dollars.

"This is not about health care. This is about the deficit," said Theodore J. Freedman, president of Mt. Sinai Hospital in Toronto. It amounts to a scary, teeth-rattling notion--health care needs taking a back seat to a federal government budget deficit. A rare occurrence? Hardly. Similar shutdowns have been standard fare since 1990 in an attempt to contain government-funded health care system costs. Also for budgetary reasons, more than 20,000 Toronto-based physicians were furloughed for one week during the early spring of 1994.

In January 1994 more than 560 eminent economists, including some Nobel Prize recipients, signed on to an open letter to President Clinton, citing concerns of an eroding quality of health care under the Administration's proposed reform plan. Their concerns centered around proposed price controls masking the true cost of medical services, diminishing the quality and quantity of care, retarding the development of life-saving drugs, and impeding advancements in medical technology.

So, today, the question before the house is this, *"What shall we now do about significant health care reform?"* Presently, six major proposals are before Congress--each distinctive, freestanding and unique. The major proposal is the Health Security Act, sponsored by the Clinton Administration.

At first blush, there would be some obvious winners from the Administration's proposal: *the working poor who would gain coverage...employers who now insure and have budgeted that expense...nurses who will have expanded roles and greater responsibilities...the uninsured and disabled who would also gain coverage...primary care physicians (family practice, internal medicine, obstetrics/gynecology, pediatrics) whose numbers are mandated to grow larger as the proposed "Gatekeepers" in the new system...the elderly and sick who could have extended coverage at home and reimburse-ment for prescriptions.*

There also appear to be those who could lose under the Administration's proposal: *anyone who has treatments delayed, cut back or rationed in order to try to contain costs...small business owners who have not*

been able to fund employee health care... medical specialists who, because of their higher costs and fees, would lose out to the preferred general practitioners in the new system...the young and healthy who would probably pay far more than their share of health care costs...and high-income taxpayers who would bear additional costs of funding universal coverage.

This monograph takes on an ambitious, nonpartisan project: (1) outlining the major alternative health care bills currently before Congress; (2) cataloging the questions and concerns that our various publics and constituencies have about such major legislative reforms of our health care system--indeed, our lives; and (3) providing some factual answers along with normative counsel on the subject.

II. ALTERNATIVE MEDICINE

The first proposal is the landmark ***Health Security Act*** of the Clinton Administration. Under the proposal, sponsored by Senators Gephardt (D-Mo) and Mitchell (D-Mass), all employers must offer, and pay 80 percent of, insurance. Everyone must have coverage, and the program would be universal in 1998. There would be standard benefits (doctor, hospital, drug, preventive care, mental health). Some home-based and community-based long-term care would be provided, and there would be low income and small business subsidies.

To control costs, the Administration's program would place caps on insurance premiums, subsidies, Medicare and Medicaid spending, along with administrative reform. The Medicare program benefits would remain as they are now, although drug coverage would now be added and the higher income recipients would pay more. The program would be structured with purchasing groups required, except for large, self-insured businesses. There would be federal guide-lines, but the states would administer the program.

The *Senate GOP Plan* by Senator Chafee (R-R.I.) differs significantly; it is titled ***The Health Equity and Access Reform Today Act.*** Under it, employers must offer, but not pay for, insurance. Everyone would be required to buy into it as it becomes universal by the year 2000. The benefits package would allow a choice between standard benefits (doctor, hospital, drug, prevention) or catastrophic coverage. There would be no long-term health care coverage, and the program would be financed solely by individuals. There would be low income subsidies.

Cost controls under the *Chafee Plan* would be maintained through market forces. There would be cuts in Medicare and Medicaid growth and a ceiling on malpractice awards, coupled with administrative reform. Medicare would remain as it now is, although there would be no drug or other new benefits. Higher income individuals would pay more under this plan, and small employers could form purchasing groups to buy insurance.

Under the *Cooper (D-Tenn.)/Breaux Plan*, titled ***The Managed Competition Act,*** individuals would pay for their health insurance; they would not be required to purchase it. A National Health Board would recommend a standard package to Congress. There would be no long-term care; low income subsidies would be available. Costs would be controlled through market forces, and there would be no caps on private sector or government programs.

The *Cooper Plan* includes ceilings on malpractice awards, coupled with administrative reform. Medicare would remain intact. However, there would be more coverage for preventive care. No extended drug coverage would be provided, and the higher income groups would pay more. The program would be structured so that purchasing groups would be required, except for large businesses.

Senator Gramm's (R-Texas) Proposal for coverage involves the employer as being required to offer, but not needing to pay for, insurance. Individual purchase would be optional. There would be no standard benefits package. Medical IRAs would be used to buy catastrophic insurance to pay expenses over $1,000 annually. No long term care would be

provided in this plan, and individuals would be responsible for the entire premium.

Cost controls under the *Gramm* proposal would be maintained through market forces. There would be cuts in Medicare and Medicaid growth. Malpractice award ceilings would be in place along with administrative reforms. Medicare would remain intact with no new benefits. Small employers may form purchasing groups to buy insurance.

The McDermott Plan (D-Wash.), called the ***American Health Security Act***, is fashioned after the Canadian system. It provides for universal coverage from startup for all Americans. The benefits package would include the standard benefits (doctor, hospital, drug, prevention, mental health), and the details would be developed by a national board. There would be long-term care in nursing homes, along with home-based and community-based care.

The *McDermott* program would be financed through taxes on employers, employees and tobacco usage. Cost controls would be maintained through a national health budget. There would be limits on provider rates and administrative reform. Medicare would be eliminated, and the beneficiaries would be placed in the national system. There would be federal standards, administered by the states.

The House GOP Program by Senator Michael requires employers to offer coverage, but they need not pay for the insurance. Individuals would not be required to purchase coverage. The benefits package would involve establishing medical IRAs to pay health care expenses; other benefits are not specified. No long-term coverage would be provided, and

individuals would be responsible for paying the entire premium. Costs would be controlled through market forces.

Under the *Michael* proposal there would be no cost caps on private, Medicare, or Medicaid spending. There would be cost ceilings on malpractice awards, coupled with administrative reforms. Medicare would remain intact; however, there would be no drug nor other new benefits. Higher income taxpayers would pay more. Small businesses may form purchasing groups to buy insurance.

As stated earlier, six plans are now being considered by Congress. There were many before, and there will certainly be others to follow. Recently, the Heritage Foundation submitted a plan that was meant to constrain Americans into becoming more sensitive to the cost of health insurance. It is their opinion that even Medicare deductibles could further increase, constraining the elderly to become more cost conscious as users. It was concluded by the Heritage Foundation that insurance rates could drop as coverage would be restricted to the more expensive procedures and related health care costs.

There, we have it. This year all Americans along with their elected officials will be examining these programs, especially the Clinton Health Security Act, to try to find cost-effective ways to have, as President Clinton has put it, *"comprehensive benefits that can never be taken away."* Early in 1994, the U.S. Chamber of Commerce and the Business Roundtable came out in favor of the Cooper Plan, dubbed by the media as *"Clinton Lite."*

Nevertheless, the future, when it comes to funding medical programs for the American people, is a moving target. It's a place we have never been before. Back in 1990 the Bush Administration attempted to predict Medicare and Medicaid spending three years out, that is, for 1993. Keep in mind that Medicare and Medicaid are long-established and somewhat predictable health care programs that have been in place for decades. The Bush Administration missed the mark, coming in $15 billion low. Obviously, that raises questions about our ability to forecast adequately and budget for major health care reform. Such is the stuff of the remainder of this monograph.

II. QUESTIONS, QUESTIONS, QUESTIONS

Rudyard Kipling once said, *"I had six honest serving men--they taught me all I knew. Their names were Where and What and When and Why and How and Who."* Following Mr. Kipling's advice, this section of our monograph is dedicated to those tough questions that need to be asked about comprehensive health care reform. Perhaps these questions could prove to be a ***Checklist*** or ***Guide*** as we collectively work through nothing less than major open heart surgery on our health care system this year and in the years and decades to follow.

These questions, some 144 of them, are grouped under 13 subtitles according to the following major themes and criteria: *(1) Rights and Privileges; (2) Role of Government; (3) Funding Requirements; (4) Administrative Challenges; (5) consumer benefits; (6) employer perspectives; (7) Employee Effects; (8) Physician Roles; (9) Patient Requirements; (10) Market Forces; (11) Price Dynamics; (12) Insurance Requirements; and (13) Leading Edge Innovations.*

A great many of these questions will then be answered in Sections III through VIII of this monograph.

Rights and Privileges Questions

1. *Is health care for all Americans a basic right for every citizen or is it, in fact, more of a privilege?*

2. *Is universal health care coverage mentioned anywhere in the Constitution?*

3. *Should each American have the freedom to choose the health care plan that is best for him?*

4. *Is comprehensive health care for all a moral imperative?*

5. *Does peoples' needs for health care supersede the freedoms of those who produce and deliver medical care?*

6. *Should government sponsor health care programs to compensate for differences in luck (such as good luck and bad luck).*

7. *How can a truly fair health care program be designed?*

8. *What criteria--medical, economic, political and social--should be used to judge fairness of health care reforms?*

9. *If personal freedom is best in every other aspect of our economic lives, is it not also right in principal on the subject of health care?*

10. *Is comprehensive and universal coverage a social experiment that has been tried elsewhere?*

11. *Is socialized medicine working well anywhere in the world today?*

12. *Does comprehensive health care reform represent the largest piece of social engineering ever in the United States?*

13. *In the long run, does socialized medicine mean decreased quality and increased cost?*

Role of Government Questions

1. *Is our health too important for Americans to entrust to the government?*

2. *Even in the health care arena, is there such a thing as a "free lunch?"*

3. *Have Canadian and British health care systems provided any lessons we could learn vicariously?*

4. *In the last three decades, which share of health spending, compared to total U.S. consumption, has grown the fastest--the government share or the private sector share?*

5. *Do we want government responsible for an additional 14-20 percent of our Gross Domestic Product?*

6. *How much would fully implemented health care reform add to the National Debt?*

7. *What other programs (welfare, environment, etc.) will take a back seat to health care reform this year?*

8. *Will centralized health care become one more means to achieve redistribution of wealth and income?*

9. *Does "managed competition" mean increased regulation, more bureaucracy?*

10. *What would happen to the size of the federal and state bureaucracies as a result of health care reform?*

11. *Is it easier to start a new bureaucracy than to dismantle an existing one?*

Funding Requirements Questions

1. *How can health care reform financing be fair and yet broad-based?*

2. *Can the health care reform package that we end up with pay for itself?*

3. *If more money is required due to incorrect forecasts of health care costs, where would the money come from?*

4. *Would there be major new taxes to fund the price tag of health care reform?*

5. *What percentage of the total health care expenditures by the government are accounted for by Medicare for the elderly and Medicaid for the indigent?*

6. *Have costs of Medicare and Medicaid programs vastly exceeded the most generous original cost projections, despite price controls on doctors and hospitals?*

7. *Who will pay health care subsidies for the poor, for small business, etc.?*

8. *What would covering 37 million additional people do to the cost of operating the health care system?*

9. *How would a nationally sponsored health care program avoid major cost overruns?*

10. *How would the final version of the health care plan control costs and reduce cost shifting?*

Administrative Challenges Questions

1. *Can there be major health care change without difficult choices and sacrifices?*

2. *Can the Clinton Administration's "reforms" goals of "security, simplicity, saving, choice, quality and responsibility" be fleshed out into a viable health reform legislation?*

3. *How manageable would a new, intricate health care reform plan be?*

4. *How would administrative costs be affected by major health care reform?*

5. *What would be the timetable for implementing comprehensive health care reforms, both on the funding side and the coverage side?*

6. *In public monopolies, even health care, doesn't bureaucratic reform and lack of entrepreneurship add to costs?*

7. *How are the pioneer states reforming "managed care" through partnerships with group medical practices such as HMOs?*

8. *Might states be allowed flexibility in choosing various health care plans under the new system?*

9. *Do we need 50 separate, state-run bureaucratic monopolies on health care?*

10. *Would "managed competition" severely limit consumer choice, choice of insurer, choice of benefits, and choice of physician?*

11. *Currently, under Medicaid, how many layers of review are there?*

Consumer Benefits Questions

1. *Do we have an honest-to-goodness health care crisis in this country?*

2. *Don't we presently have the best health care system in the world?*

3. *Should there be access to coverage for all employees--not free, not required, just access?*

4. *Will this Administration's planned Standard Benefits Package be as good as what most Americans are used to now?*

5. *What will happen to the demand for medical services if health care becomes cheaper, seemingly free, and/or universal?*

6. *Will price controls on goods and services in the health care industry lead to shortages, rationing, etc.?*

7. *When everything is said and done about healthcare reform, will patients travel further and wait longer for medical treatment?*

8. *What assurances can be put in place that Medicare would remain intact and/or improved?*

9. *Would coverage of 37 million previously uncovered citizens, which amounts to 15 percent of our population, still allow for the system to provide quality care?*

10. *Under a newly reformed system, would special health care needs be addressed for urban dwellers, rural dwellers, and regardless of income or age?*

11. *Can we afford to have home-community-based and nursing-home care available to people regardless of age?*

12. *How can we find an acceptable balance between providing more access to health care services and maintaining high-quality care while also containing costs?*

Employer Perspectives Questions

1. *Up to now, haven't employer-paid health plans been one more course in the "great American free lunch" in the minds of most employees?*

2. *How much would it cost American businesses, large and small, to fund coverage of comprehensive, universal health care coverage?*

3. *Might health care reform bail out big business while pushing small businesses closer to insolvency and bankruptcy.*

4. *Doesn't this drive a wedge between the real consumers and the real providers, obscuring the real cost of health care coverage?*

5. *Will the taxpayers end up bearing the financial burdens for big corporations which, in the past, made unrealistic commitments of generous health benefits to their retirees?*

6. *How much would the new health care reforms dramatically reduce the health care costs for many large, high-wage companies such as automakers?*

7. *Would large corporations dump their early retirees into a national system to avoid health care costs?*

8. *How big a payroll tax on business would be required to upgrade coverage for Medicaid beneficiaries, thereby pushing them into new health insurance purchasing pools?*

9. *Would some workers be laid off to reduce a company's health-insurance burdens?*

10. *Can the business sector become a more demanding buyer by overhauling the way it purchases health care, steering workers to providers who perform best?*

Employee Effects Questions

1. *Would universal health care coverage be available regardless of employment status?*

2. *How much less would the employee receive in take home pay because of funding requirements for the new health care system?*

3. *How would the funding for major health care reform affect employment and unemployment?*

4. *In terms of health care reform language, who is considered an employee?*

5. *How can the security and affordability of health insurance be safeguarded for workers who change jobs or get laid off?*

6. *For the low income worker, doesn't the deductible in the traditional insurance policy offer as a disincentive, and then later*

an incentive, toward spending throughout the calendar year?

7. *Is the public ready for price increases, and possible job losses for small firms, to pay for health care reform?*

8. *How would part-time workers be covered under a newly reformed health care system?*

9. *What about comprehensive health care for freelance workers, independent contractors?*

10. *Would it be advantageous from a cost standpoint for the employer to convert employees to independent contractors?*

11. *How would the proposed health care reform packages handle the funding requirements of the self-employed?*

Physician Roles Questions

1. *Are doctors and hospitals committed to working toward reform, regardless of what happens to the plans now before Congress?*

2. *Assuming that both patients and doctors support health care reform, how can it be best accomplished to keep real-world, doctor-patient relationships intact and the quality of service high and rising?*

3. *Under a new system, will Americans be able to keep their doctors? At what cost?*

4. *Looking back, didn't health care providers amply adjust to Medicare and Medicaid when those programs came along in another era?*

5. *How easy will it be for the 500,000 doctors and 7,000 hospitals in America to change the way they deliver medical care?*

6. *How many "gatekeepers" will there be after health care reform?*

7. *Could creating large networks of doctors and more levels of regulation create more micromanagement of health care?*

8. *Under comprehensive health care reform, will doctors have less control over the treatment of patients than they had before?*

9. *How easy will it be to change the way 250,000,000 Americans buy their medical care?*

10. *Currently, what percentage of total physician costs is paid by the government?*

11. *Under the new system, what exactly would the phrase "Pregnancy Related Services" include? Abortion?*

12. *Will doctors or hospitals affiliated with the government-sponsored plan be able to opt out of the above under a "conscience clause"?*

Patient Requirements Questions

1. *Should decision-making control over medical services rest only with the patient?*

2. *Under comprehensive health care reform, could Americans buy additional coverage if they wanted to?*

3. *What percentage of Americans will be without health care coverage sometime in the next two years?*

4. *Do Congress and the president need to make each American more conscious of health care cost on the personal level?*

5. *Is preventive medicine for the uninsured less expensive than last-minute visits to the emergency room?*

6. *Do the current health care plans have too few consumer choices in them?*

7. *Will the health care reform bills lead to longer waits for service, deterioration of facilities, and a slowdown in the adoption of new medical technologies?*

8. *When health care consumers believe that someone else is footing the bill, what does that tend to do to their health care costs?*

9. *Will universal coverage be like putting all Americans on Medicaid (originally designed for the poor)?*

10. *Why are senior citizens, never shy about telling Congress what they think, so conspicuously quiet now regarding the Administration's health care reform proposal?*

11. *Should we require consumer alliances to which everyone would belong?*

Market Forces Questions

1. *Would the new health care reforms hold down the income of many doctors, hospitals, insurers and drug manufacturers through stiff federal cost controls?*

2. *What would the above-mentioned disincentives do to the amount of health care that is provided through the pipeline?*

3. *Do medical school debts sometimes nudge graduates into higher-paying specialties in an attempt to service these debts?*

4. *What is our ratio of medical specialists to all physicians, compared to other western nations?*

5. *If there are fewer specialists, will we have to ration these leading-edge forms of health care?*

6. *Right now, what percentage of hospital costs are government-paid?*

7. *What if hospitals and doctors have to shift costs to the private sector to make up for low payments from government programs?*

8. *Will it become legally and financially risky for physicians to operate outside of government-sanctioned health consortiums?*

9. *Do additional paperwork and governmental oversight have some embittered physicians already to the point of quitting?*

10. *Will we end up with a two-tiered system in which most Americans would be plugged into a "take-a-number" medical assembly line, while the rich could afford the best possible care?*

11. *Will the new health care system push Americans away from private doctors and into less expensive group medical practices, such as HMOs?*

12. *In the end, must universal coverage be sacrificed at the expense of cost control?*

Price Dynamics Questions

1. *How much more or less will health care cost the average individual under a new, reformed system?*

2. *Could health-cost spirals be broken by informed consumers who have the incentive to choose the basic plan that delivers service with the best combination of quality and cost?*

3. *What would happen to the stock prices of low- cost health care alternatives?*

4. *How would increasing comprehensive health care costs affect individual product prices?*

5. *How would rising universal health care costs affect inflation in general?*

6. *How would additional health care costs affect production-factor costs and, thereby, foreign and domestic market shares for American industries?*

7. *What effect would price controls have on the research incentives for new drugs and breakthrough medical technologies?*

8. *Percentagewise, how much more do Americans spend on health care per person than the next most expensive country, Canada?*

9. *How much more would the average American pay as a customer for similar health coverage under a new plan?*

10. *In health care, as in everything else, in the long run don't we get what we pay for?*

Insurance Requirements Questions

1. *What percentage of all Americans now have health care insurance and ready access to doctors and hospitals of their choice?*

2. *Does health care cost shifting to third parties (insurance companies, government, etc.) encourage overuse?*

3. *Are the twin goals of comprehensive universal health insurance and cost control at odds?*

4. *Will health care reform be to the advantage of larger insurance companies over smaller ones?*

5. *Could health care insurers aggressively compete for customers on the basis of benefits offered, crafting policies to truly meet the need of the purchaser?*

6. *Would the new health care reforms result in relieving consumers from the nightmare of medical billing and insurance claim forms?*

7. *To what extent would the new health care reform costs go up for the businesses that now pay little toward workers' health insurance?*

8. *Would it be possible to successfully and smoothly mandate employer-paid insurance?*

9. *As a result of the new health care reforms, will the physician be responsible to the insurer or to the patient?*

10. *What would happen to health care costs if a cap were put on malpractice awards and contingency legal fees?*

11. *Why should juries care how big an award they give in a malpractice suit, if the jury doesn't pay the award?*

Leading-Edge Innovations Questions

1. *For any health care program to work, doesn't the entire system need a productivity revolution?*

2. *Can our health care system operate more efficiently through restructuring it to create incentives to save money?*

3. *If we don't orchestrate health care change, will the change orchestrate itself?*

4. *Could privatization be accomplished through vouchers provided at state level for medical care coverage, with recipients pooling vouchers into group policies?*

5. *Could tax credits be used to focus government health care help on those who really need it?*

6. *Should health care buyers band together in large alliances to bargain with competing networks of health care providers?*

7. *Could other forms of health care coverage offer "lifestyle incentives" or rebates for nonuse?*

8. *Could there be some tax incentives for companies that fund "wellness programs?"*

9. *Could individual medical accounts (tax-free IMAs) be another key to controlling health care costs, strengthening the role of the individual as health care consumer?*

10. *Is it possible that the new world of instant, electronic billing could be part of health care reform?*

III. KEEPING THE DOCTOR AWAY?

"How can anyone," asks *Chicago Tribune's* Mike Royko, *"know how much a doctor should earn, when few know what it takes to become a doctor?"*

> *Excellent grades in high school and college with a heavy load of math and science classes...four extremely challenging years in medical school...including two demanding years of clinical rotation with its 70-hour weeks...one more year as an Intern...followed by perhaps four to six years of specialized training...and topped off with a career of more 70-hour workweeks and a potential post-graduate debt load in six figures.*

And we're all familiar with the bumper sticker slogan, *"Don't cuss a farmer with your mouth full."* Well, there is a corollary to that when it concerns our medical doctors. This schizophrenic piece comes from the *Indianapolis Medical Society Bulletin*: *"When you are in need of a physician, you esteem him a god. When he has brought you out of danger, you consider him a nobleman. When you have been cured, he becomes a mere human. When he sends you a bill, you think him a devil."*

Should we switch to trusting our government more and our doctors and ourselves less? Anyone who prepares so many years for a medical career and is dedicated to alleviating pain, increasing mobility, enhancing quality of life, mending broken bodies, defeating disease, warding off premature death--managing all that--has this writer's undying gratitude.

There are those who say that there has been an oversupply of doctors for the last decade. Not so. There is an oversupply in some urban areas; there is a shortage nationwide of primary-care physicians in rural and inner city hospital settings. If anything, a growing supply of doctors could help reduce the workload of existing physicians, shorten their work week, and upgrade the quality of medical care.

Just as we especially appreciate doctors who listen intently to us as patients, now is the time for all good Americans to listen to our various medical scientists for solutions to our health care reform dilemma. Wouldn't it be a shame if the answer were right under our nose, and we blew it?

IV. THE GREAT AMERICAN FREE LUNCH

Nothing is free. Everything in our economic lives has a cost that must be paid by someone, sometime, somewhere. Accordingly, we need to include more than just a word of caution regarding seemingly free and limitless regulatory reforms of health care in America. These comments mirror some that this writer made in congressional testimony a few years back regarding regulatory reforms and their affect on small businesses. Certainly, these statements fit here, too.

As I told the congressmen, most of us have heard those sage observations over the decades regarding government and the marketplace:

> *That government which governs best--governs least ... Government can be like a mother-in-law--a good policeman but a poor problem solver ... Government starts out looking like Santa Claus and ends up becoming Frankenstein ... Government is like fire--a dangerous servant but a fearful master ... Government should be like your stomach--if it's working right, you don't know you have it--if it's not, watch out ... Government has shifted from the role of protector to that of provider with a redistribution mentality ... Government should not take care of us from the cradle to the grave--womb to tomb--while we spend our time filling out paperwork ...*
>
> *... Government should not be someone who looks after you and then comes after you ... The legitimate task of government is to do for people the things people cannot do for themselves*

... Government is the fiction in which everyone plans on living off everyone ... When it comes to social engineering, we all see ourselves as planners, seldom as plannees ... Is it impossible for a government to interfere with a balanced, integrated market system without creating distortions, many of which are counterproductive ... Government solutions frequently reward the inefficient and penalize the productive, which the market wouldn't allow ....

... Intrusions of government in the market can create confusion ... Government solutions, when successful, can be extremely costly ... Government intervention can disrupt economic communication signals, making it more difficult for consumer signals to reach producers ... Government intervention can reduce the flexibility of producers in adapting to changes ... Government intervention can hinder the introduction to the market of new ideas, new products, new methods, etc.

So, there we have it: perverse results despite the best of intentions. Baron Von Frankenstein was a man who meant well. Death distressed him, and with the best intentions he sought to *"recreate life."* Using trans-plants, he made a dead man live--producing an unnatural creature who was at first benign, but rapidly deteriorated into a fiendish monster.

As we continue to explore health care reform alternatives, let's be super-careful to do only those things that continue to give decent life to the actual system that supports us both materially and physically--our economic horn of plenty that we call free, private enterprise.

V. THE COST OF HEALING OURSELVES

Nobel economist Dr. Milton Friedman has often stated, *"Watch how people vote with their feet when they can vote no other way."* Where do the world's rich and famous go for their medical care? To the U.S. of A. Not so coincidentally, over 600 Canadian physicians fled to America in 1993. So, where is the health care crisis, if we are the envy of the planet when it comes to medical treatments, techniques, pharmaceuticals, physician availability, etc? Inquiring minds want to know.

Who are the 37 million uninsured, and why? First of all, its membership is constantly changing, and it amounts to 15 percent of our total population. Some are between jobs. Others are young and healthy and/or old and rich. They often choose not to buy insurance. Many have spouses who have coverage for these dependents. Some honestly believe that it is the responsibility of their family or church to accept liability and pay for health care-related debts. And yes, many are poor, need medical care, and don't receive it.

Tough questions have to be asked. Because there are some homeless people, shall we convert everyone to public housing? Because others go hungry, shall we collectivize agriculture? Eastern Europeans have learned the answers to those questions the hard way.

That oft-stated number of 37 million Americans not covered by health insurance is inflated. According to the latest data from the Health Insurance Association, two-thirds of the uninsured families have at least one fully employed worker, usually either self-employed

or working in a small firm. Some of the number are, in fact, also young people who, because of their youth and good health, have opted to spend their money on other things--a choice this middle-aged writer would not make. Nevertheless, we do live in a land of free choices--for now.

And those who are poor and homeless, although they may not be insured, don't necessarily do without health care. It's just that when they do receive health care at emergency rooms and trauma centers, it is usually of the most expensive type and involves a lot of cost shifting to various third parties.

In the United States, according to a recent survey by the Gannett News Service, only 25 percent of total health care costs are paid by the patient. The remaining 75 percent is paid by employers or the government. Today 63 percent of hospital costs are paid by the government. The government also pays 48 percent of total physician costs. Of the total health care expenditures by the government, 42 percent are accounted for by Medicare for the elderly and Medicaid for the indigent (double what it was 30 years ago). By the year 2003, Medicare is projected to be as expensive as Social Security. Medicare costs rose a highly significant 25 percent in 1993.

Consequently, the American patient expects the finest health care there is and also expects cost shifting to third parties to absorb most of the personal financial burden. Can this all continue?

VI. PAYING THE BILL

Considering all the goods and bads of our current health care system, if there is an agreement on anything, it is that, as it now stands, our current health care system cannot be continued into the future years and decades. Costs appear to be going up too rapidly, being shifted too frequently, and the number of people who are uninsured is approaching 40 million. In the long run, these factors are all extremely destabilizing to the status quo in health care as we know it.

The world operates not only on what is true, but also on what people believe to be true. This was verified by a recent survey by Northwestern National Life of several hundred employee-benefit managers. Their opinions varied widely on what was driving up health care costs.

There is no easy answer to the riddle; however, included on the list would certainly be the following items: *(1) population growth, (2) aging, (3) affluence, (4) frequency of physician utilization, (5) medical practice expenses, (6) malpractice insurance premiums, (7) office expenses, (8) marketing costs, (9) new technology, (10) in-patient vs. out-patient demand, (11) competition, (12) uneven hospital capacity utilization, (13) uncompensated care, (14) cost shifting, (15) administrative overhead, (16) increases in mandated benefits, and (17) past cost-containment failures.*

All of the above causes are outlined in a signal publication titled The Crisis in Health Care: Costs, Choices, and Strategies. The authors of this 1990 book--Coddington, Keen,

Moore and Clarke--do an excellent job of cutting through the problem and clarifying it as much as possible. Each of the authors is a consultant specializing in the health care field. It is recommended reading for anyone who would like to know more about this thorny topic on our national agenda.

It is the opinion of those authors that (1) there is little hope that cost increases for health-plan payers will be moderate; (2) the system is too fragmented (many payers, many providers); and (3) there is little incentive for providers to change the way things are. Therefore, the current health care system is not sustainable.

All the major players are taking sides. The insurance industry hopes to reduce the price ceilings on premiums and avert attempts to replace insurance companies with a governmental single payers system. Consumer action groups tend toward wanting a Canadian-style system. Labor unions are pushing for generous universal benefits packages and are in opposition to a taxation of employee benefits.

Lawyers are opposing the reduction of contingency fees and lowered caps on jury awards. Drug companies are lobbying to prevent price controls on pharmaceuticals. Doctors, nurses and hospitals are working through their professional associations to avert limits on physician fees and hospital charges.

Other groups representing the alcohol and tobacco area are lobbying to block large tax increases on their products as penalizing the poor. The powerful American Association of Retired Persons (AARP) is quietly but firmly lobbying for greater long-term care and

prescription coverage. AARP includes nearly 40 million voting-age Americans (who vote at twice the percentage of the average young person). It may be the strongest special interest group in the country.

VII. TAKING OUR MEDICINE

Perhaps if we take the long view, the following perspective is helpful. As my son started medical school, I asked an area doctor, *"What will health care be like, for both doctors and patients, when my son graduates from medical school and is practicing as a physician?"* His reply was to the effect that *"the change would be so gradual, between now and then, that the participants wouldn't know what they missed along the way."*

That's probably true. Just think back to the 1960s and remember that our health care providers--doctors, nurses, hospitals, insurance companies--have all adapted handily over the years, if not always willingly, to the changes that have come with the major reforms of that era--Medicare and Medicaid. No doubt, when everything is said and done, we will probably get the health care we need, and we will pay for it.

Then there is the tale about the neighbor who had to be admitted to the local hospital for treatment. During a visit his friends remarked that he had a nice, pleasant room, although the price seemed quite high. *"True,"* the patient commented. *"It does seem like a lot of money, but remember, they give us some mighty long days in here."*

Yes, here in the late 20th century, we're now treating diseases so rare they haven't even held a telethon for them yet. But if our doctors and hospitals--truly the world's finest--remain worth their sodium chloride, they'll have us up and complaining about their bills before we know it.

Probably one source of containing rising health care costs would be Americans developing more healthful lifestyles. It has been said that health is a crown on a well person's head; yet, no one can see it but a sick person. We all live, laugh, love, grow, mature and die. Our doctors have trained and dedicated themselves to help us try to keep things in that proper order.

If we do change the direction of health security or national health insurance, we need to realize what *"socialized medicine"* is all about. Talk to any American Indian, any veteran, etc. It's possible that under such a system we'd find that medical decisions would not be made by us, nor by a doctor, but rather by state employees or federal employees responsible to Washington.

Under socialized medicine, our medical records could become no more private than a phone book. Let's also remember that the government cannot provide medical care any more than the government can grow food. Doctors, nurses and hospitals provide medical care, just as farmers grow food.

Again, talk to that American Indian, that veteran or anyone who receives medical care from the federal government. Socialized medicine is neither a new idea nor an experiment with an unknown result. Many countries of the world have it, and it often comes in tandem with poor quality of care and longer waits for service. As with any form of price controls, rationing is what we are describing here.

The British government estimates that, at any given time, 1 million British citizens find their names on waiting lists for major medical

care. The estimate for Canada is 250,000 people whose quality of life is short circuited by rationing--unless, of course, they go outside the system and pay for medical care in the private sector (for comparison, the U.S. population is nearly 10 times larger than Canada's).

Sure, America's health care costs are higher per capita than Britain or Canada, but perhaps the old adage still applies, *"You get what you pay for."* Getting the health care we need is far different than getting health care when we need it.

VIII. WON'T HURT A BIT?

In the past, some economists have deservedly gotten into trouble for promising more than they had a right to deliver, usually in terms of forecasting future events. What people want most from us economists is that which we are least able to provide--a detailed forecast of the next 30 to 90 days. The best we can do is put all the known variables on the scales and try to point out which way the scales are tilting.

The same is true with our health care system and government in general. We are creatures of great contradiction. We distrust government, and yet we want more from it. We all want good health care regardless of our ability to pay. We each do not want our choices limited in any way, and yet we don't want to be made to feel poorer by rising health care costs. Above all, we seem to be reluctant to deal realistically with these mutually exclusive goals.

As we examine all the major health care reform proposals on the table, let's consider that it is also possible that little change will be forthcoming. All of life is a compromise. In the recent past, Congress hasn't been too willing to become involved in health care issues. Additionally, any change would be supported, as well as resisted, by countervailing and powerful special interest groups.

How can we keep these significant reforms--eliminating waste, lowering overhead cost, bypassing unneeded tests and operations, etc.--from clashing with the above-mentioned public preferences for the best of care and the maximum freedom? With so many mutually

exclusive goals and special interests to be satisfied, is the problem solvable? Yes, probably through compromise, we can become more realistic and develop a health care system that can be more fair, more durable and more efficient than today's patchwork system.

And by the way, the elderly in general, and specifically my friends who are members of AARP (at 51, I'm an Apprentice Senior Citizen), will not like this: It is a myth to say that the elderly are poor. The percentage of the elderly in poverty differs very little from those of the overall population. For decades it has hovered between 11 and 14 percent. However, be advised that taxes bearing too heavily on the younger folks involve nothing less than an inter-generational transfer of wealth from the young to the old. We need to be extremely careful about that.

Yes, per capita health care in America costs approximately 30 percent more than in Britain, Canada and France. What has gone relatively unnoticed is that if we examine the last two decades, and look at annual per capita cost increases, then the rates in Britain, Canada, and France have been rising much faster than ours. They have taxpayer-funded, government-administered national health insurance schemes.

The countries with the lower annual per-capita increases in health care costs over the last two decades are Germany, Holland, Japan and the United States. Not so coincidentally, all have systems wherein there is active competition, not only among those who provide health insurance but also among those who provide health care.

And who will pay the AIDS bill? Not the insurance companies, if they can help it. More cost shifting is in the works--and with it a range of options: state-run risk pools, national health insurance, and possibly some public hospital crises. One way or another, either through higher premiums, higher prices, lower wages or higher taxes, etc., the population at large will be bearing the burden of the cost of AIDS, no matter what the new health care system becomes.

Can we have it both ways? Can we say, *"I expect the best hospital care, no matter what the cost,"* and at the same time insist that hospitals must get their costs in line with what we can afford? The question answers itself.

SUMMARY--EFFECTING THE CURE

So there's the riddle: how to provide better public access to health care, retain patient control, preserve doctor-patient relationships, while focusing on the quality of that health care. However, regardless of what happens in our national debate over health care, it is good to know that it is on the agenda. Perhaps it is true that a problem well-defined is half-solved. If so, then this monograph has taken at least an intermediate step toward that goal.

If, when we enter the medical marketplace, we are mostly spending someone else's money rather than our own, then perhaps in the name of better stewardship, a "Tax-free Savings Account for Medical Expenses" much like our Individual Retirement Account (IRA) has some merit as a form of honest-to-goodness private planning. Accordingly, we as individuals could set money aside for routine medical expenses and use health insurance for major medical episodes.

Such was the recommendation recently of the National Center for Policy Analysis in Dallas. They recommend that individuals should be allowed to make tax-free deposits each year to individual *"Medisave Accounts"*--a type of self-insurance and an alternative to the use of third-party insurers for routine and minor medical bills. The approach, although a bit simplistic, seems to allow for a maximum amount of freedom for the individual, rather than having his decisions made by someone else, an insurance company or the government, who may not fully know his situation.

Optimistically, there may very well be other ways in which comprehensive health care reforms might be good for everyone. We could all start by improving our health habits. Better and more timely health care could reduce employee absenteeism and boost worker productivity. Streamlining health care programs could boost competitiveness, reduce waste, and eliminate unnecessary tests and procedures. Lower caps on malpractice awards, coupled with greater accountability by juries, could return us to greater reasonableness in medical care.

Entrepreneurism in health care could create lower cost approaches to a broad range of medical and administrative procedures. As is now happening under the umbrella of managed care, new niches are being created as health care providers reorganize, cut costs, develop greater efficiencies, form alliances, innovate, consolidate, network, integrate, unite, etc. Just as we have seen circumstances evolve in retailing, so can health care providers move the direction of better and more timely patient care through one-stop shopping.

In the meantime, what to do? Eat right, breathe deeply, live uprightly, cultivate serenity, maintain a healthy outlook toward life, make your peace with your Creator on His terms, live as to neither be ashamed of yesterday nor fearful of tomorrow, and check the newspaper obituary column each morning; if your name isn't there, give thanks, and have a great day!

The debate goes on; that's good. In all probability, our political leaders and their respective parties, along with all the special interest groups, will blend their various

proposals into a final plan allowing for, however not requiring, all U.S. citizens to buy into at least a nominal level of health care coverage.

John Milton once said, *"When there is much desire to learn, there, of necessity, will be much arguing, much writing, many opinions; for opinion in good men is but knowledge in the making."* Let's hope so and work toward that end. Then, the coming generations, who will be the true judges of what we do today, will find us worth of our task.

The ***ENTREPRENEUR*** is a quarterly journal and newsletter addressing contemporary economic issues from a moral perspective. One may not agree with every word printed in the ***ENTREPRENEUR*** series, nor should feel he needs to do so. It is hoped that the reader will think about the points laid out in the publication, and then decide for himself.

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