Saint Paul Legal Ledger
DOLAN MEDIA COMPANY

November 28, 2008

Look Out for Myths About Government-Provided Health Care

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Federal, state and local governments already spend roughly half of all health care dollars in this country, and they have a large say over how the other half is spent. As a result of the last election, it's likely that government will have an even more significant influence—if not control—over how all health care dollars are spent.

So what can we expect? Nothing good, as far as I can see.

Sally Pipes has seen some of the future in her native Canada (she's a naturalized U.S. citizen now) and she talks about Canada, and more, in her recent book "The Top Ten Myths of American Health Care."

Pipes, president of the San Francisco-based Pacific Research Institute, was a member of GOP California Gov. Arnold Schwarzenegger's transition team, and she advised Rudy Giulianai's presidential campaign on health care policies. She has served as president of the Canadian Association for Business Economics, and her commentaries have appeared in New York Times, Washington Post, USA Today and other leading newspapers.

At 150 pages before notes, Pipes' book is short; it's also written in an easy-to-read style. These are what she calls the Top 10 myths about government-provided health care.

1. Government health care is more efficient than the private sector.

2. We're spending too much on health care.

3. Forty-Six million Americans can't get health care.

4. High drug prices drive up health care costs.

5. Importing drugs would reduce health care costs.

6. Universal coverage can be achieved by forcing everyone to buy insurance.

7. Government prevention programs reduce health care costs.

8. We need more government to insure poor Americans.

9. Health information technology is a silver bullet for reducing costs.

10. Government-run health care systems in other countries are better and cheaper than America's.

Let's start with efficiency. Does government spend less on health care, since it doesn't have to run a profit? Pipes notes, that according to the Medicare Trustees Report, administrative costs for Medicare are 1.5 percent of expenditures, versus 25 percent for some private insurance plans.

Does that make "Medicare for all" a good idea?

No, according to Pipes. First of all, other estimates question the validity or applicability of those estimates. The Council for Affordable Health Insurance, an Alexandria, Va.-based trade group, pegs Medicare's administrative expenses at 5.2 percent and those of the private sector at 8.9 percent. And if the self-interested nature of that group bothers you, consider PricewaterhouseCooppers, which pegs private-sector expenses at 6 percent. Further, some economists would factor in economic losses stemming from money being diverted from the private sector to government coffers.

There are other costs to government programs that a simple look at their budgets dollars won't reveal. Medicare and Medicaid are notorious for their low reimbursement rates, meaning that Medicare and especially Medicaid patients can find it difficult to find doctors who will take new patients. Another hidden cost, by some estimates, is that people with insurance pay another 10 percent just to help make up the difference for lowball rates from government programs.

There is still yet another hidden cost to government health programs, and that's the enormous sum of unfunded liabilities (projected expenses less project revenue) hanging over Medicare and Medicaid. You've heard that Social Security has problems? Those problems are nothing compared with those related to Medicare. As a result, the Medicare payroll tax may have to reach 6.4 percent, a dramatic climb from its current rate of less than 2 percent. The effects will reverberate throughout the economy.

So whether government health care is measured by current dollars, future payments or delayed care, it is much more expensive than advertised.

With that myth discussed, Pipes spends the rest of the book addressing specific proposals for government action. Such actions would allegedly reduce costs, introduce efficiencies and give everyone insurance—except, according to Pipes, they wouldn't. What they would do instead is have unintended consequences, she argues, including making us more sick and costing more (in dollars and much more) than we could ever know.

Take the myth that we're spending "too much" on health care. Too much? Says who? We all have one life, and if we are spending more on health care than we used to, that's because we can.

Trying to save money on drugs by squeezing drug companies or denying patients certain expensive drugs can incur greater expenses later on through causing fewer new drugs to be discovered or requiring patients instead to seek surgery.

Health technology, meanwhile, is worthwhile, but it should develop organically, not be imposed from a central location, Pipes says. Top-down approaches will likely lead to costly errors.

Preventive health programs may be the fad of the day. They are, however, a good example of how something that is individually rational may not be socially rational—and why focusing on the short term can produce inaccurate conclusions.

If we all stop smoking, start exercising, and lose weight—all things that government offices and some private companies are now prodding us to do—we will enjoy a greater quality of life. But we certainly won't save money on health care, contrary to the premise of these "good for you" programs.

Why? People will live longer. That's in itself a good thing. But people living longer also means they'll rack up more medical expenses. And since the public purse covers most medical expenses for everyone older than 65, increasing longevity increases the risk exposure of Medicare.

Pipes says that "true reform of the health care system requires less government interference—not more." Her closing recommendations propose to make more use of retail competition (retail health clinics, cross-state sales of insurance) as well as some standbys such as tort reform.

Whether anyone in Washington, or St. Paul will listen, is another story.