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American health care policy needs The Cure

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“Universal coverage” is the rage across the nation, with proposals for individual mandates, business mandates, the expansion of government programs or all three. Health care is likely to be a major issue in the 2008 elections.

One think tank author, Dr. David Gratzer, thinks that the future lies not in any of these proposals, but in making more effective use of personal incentives and improving existing programs. Gratzer, a psychiatrist by training, is a senior fellow at the Manhattan Institute for Policy Research (http://www.manhattan-institute.org).

His book, “The Cure: How Capitalism Can Save American Health Care” explores the paradox in health care. American health care technology and medicine is outstanding. Life expectancy is up, for example, and cardiac surgery is routine, as is an excellent prognosis for low-birth-weight infants.

Yet health care policy leaves much to be desired. Insurance premiums have increased at least 8.2 percent each year since 1999, and some 46 million people are said to be without insurance. Spending on public programs threatens to crowd out other priorities. States’ spending on Medicaid (now over $330 million) exceeds that of K-12 education, and the baby boomer generation is heading into the years of high medical expenses.

More subtle but other serious policy problems exist as well. Millions of people are in “job lock,” toiling away in jobs they don’t like, simply to keep a health insurance package. For many losing a job means losing insurance coverage—that is, if their employers haven’t dropped it already.

How did we get here?
“Why is it,” Milton Friedman asks, “that in every other field where enormous technological strides have been made, total costs have *fallen* over time, but in health care they have increased?”

One explanation goes back to 1943. Companies had started paying for employee health insurance as a way around wartime wage and price controls. On October 26, 1943, the IRS ruled that companies could deduct these costs as a business expense. That decision set in motion the practice of third-party payment for routine medical care.

Shielded from the cost of insurance, the public has increased its appetite for medical spending to match the advances in medical technology. And why not? As one former health care official in Maryland observed, “using health care in this country is like shopping with someone else’s credit card.”

It took another 30 years for public officials to take dramatic measures to constrain spending. Richard Nixon and Ted Kennedy teamed up to introduce managed care to the nation, and eventually business followed suit. While managed care did reduce costs, some of its restrictions were eventually loosened in the face of a consumer backlash.

Where do we go?

Since the late 1990s, consumer-driven health care has tapped this consumerist attitude, as well as business concerns over rising premium costs. It is often expressed through the pairing of high-deductible insurance policies for unpredicted, major expenses with tax-favored health savings accounts (HSAs) for routine, predictable expenses. Consumer-driven health care proceeds on the premise that the costs of medical care and insurance should be transparent to the patient, who will then act accordingly.

One criticism of this new approach is that people are too ignorant or foolish to make their own health decisions. It’s simply not true. The advent of WebMD and other information sources demonstrates that there is a demand for health information. Gratzer mentions that it is now routine for his patients to come to consultations armed with questions and information gleaned from the medical literature.

Another objection to the consumer-driven approach is that the rich will use HSAs to shelter their wealth.

But if tax fairness is the concern, the current tax code is already inequitable. Two people with identical salaries will have different levels of total compensation if one works for a company that pays for insurance and the other does not. That’s horizontal inequity. If two people work for the same company, the tax deduction benefits the higher-paid employee more than the lower-paid one. That’s vertical inequity. In this light, Gratzer argues, HSAs “hardly make the situation worse.”

There is much more to reforming health care than instituting widespread use of HSAs and high-deductible insurance plans. For example, numerous regulations on health care and insurance should be modified if not repealed.

The consumer-driven logic can and should also be applied to Medicaid and Medicare, when possible. Preventive medicine should be free, for example, but individuals should be given a voucher (adjusted for age and risk) that can be used to purchase insurance or services. We already have a model. It’s the insurance plan used by 9 million federal employees, including members of Congress, and their dependents.

One way or another, health care costs will be controlled. Who will do it? Bureaucratic managers, private and public? Or millions of people making decisions about health care spending as explicitly as they make decisions about everything else?

The era of Organization Man, which was the golden age of third-party insurance, is over. There still may be a place for employment-based pooling, but new options will have to be added. Only then can health care policy be as advanced as health care technology.