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Our Health Care System at the Crossroads: Single Payer or Market Reform?

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Introduction

Robert M. Sade, MD

In the 1940s, two decisions by federal agencies laid the foundation for the employer-based health care financing system that has characterized United States (US) health care for the last 60 years: the Internal Revenue Service's designation of funds paid by employers for employees' health care as tax-deductible and the Federal Trade Commission's acceptance of health care benefits as bargaining chips in labor-management negotiations. The health insurance industry that has grown out of that foundation has many strengths and weaknesses. Public discourse over the last half century has focused on the weaknesses, a long list that is topped by lengthy periods of double-digit inflation that is well above the inflation rates of other goods and services and an increasing number of uninsured individuals—now more than 45 million, about 15% of the nation's population. Attempts to address these problems through legislative remedies have produced only limited successes, and the problems continue to grow.

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Many believe that the piecemeal legislation of the last 60 years is doomed to failure, and that lasting improvements in the health care system can be achieved only through radical change. Two fundamentally different approaches to health care reform have dominated policy discussions in recent years: creation

of a centrally organized system designed to ensure that every American has health insurance versus devolution of our heavily regulated health care financing system toward a minimally regulated free market in health care.

Politically, the last major attempt to create a centrally organized system at the national level was the Health Security Act of President Bill Clinton's administration in 1993–1994. The first important modern step toward a free market approach to health care was embodied in the Medicare Prescription Drug Improvement and Modernization Act of 2003, which created Health Savings Accounts. Further movement toward market reforms, such as refinements of Health Savings Accounts and changes in the tax code to give individuals the same tax-preferred treatment of health insurance expenditures as employers, is high on President George Bush's agenda for his second term. The new Congress, with both Houses controlled by the Democratic Party, is likely to push for a nationalized system of some kind.

Our nation is at a crossroads because these two approaches to health care reform are based on vastly different premises and visions of the ideal health care system. They are fundamentally incompatible. We are fortunate to have premier leaders of the respective policy camps on this issue to debate the question of which road the nation should take. David Himmelstein and Steffie Woolhandler are associate professors of medicine at Harvard Medical School and are cofounders of Physicians for a National Health Program, a leading advocate of national health insurance. John C. Goodman is founder and president of the National Center for Policy Analysis and is generally credited with creating the idea of health savings accounts and is a leading advocate of free market reforms in health care.

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Pro

David U. Himmelstein, MD, and Steffie Woolhandler, MD, MPH

Almost all agree that our health care system is dysfunctional. Forty-five million Americans have no health insurance, resulting in more than 18,000 unnecessary deaths annually according to the Institute of Medicine [1]. Tens of millions more have inadequate coverage. Health care costs will reach \$7498 per capita this year, 50% higher than in any other nation, and continue to grow rapidly. Market pressures threaten medicine's best traditions. And bureaucracy overwhelms both doctors and patients. Opinion on solutions is more divided.

Discussion of health reform was muted in the 1990s after the defeat of President Clinton's Byzantine scheme for universal coverage. But now, the accelerating collapse of employment-based coverage under the pressure of globalization is reopening debate. Firms like General Motors (GM) and Ford are crippled by the growing burden of health costs, which add \$1500 to the price of a GM car versus \$419 for a German Mercedes and \$97 for a Japanese Toyota [2]. Meanwhile, low-wage employers like Wal-Mart gain competitive advantage by purchasing goods made overseas (where health benefit costs are low) and offering only the skimpiest of health coverage to their US workers. Governments face a double whammy: ever-expanding benefit costs for their employees (eg, teachers, firemen, and police) as well as sharply escalating costs for public programs such as Medicaid and Medicare.

As employers attempt to shed the costs of health care, working families increasingly find care and coverage unaffordable. In 2005, 18% of middle-income adults lacked health insurance for at least part of the year, up from 13% in 2001 [3]. Nearly a quarter of Americans report being unable to pay medical bills, and 13% had been contacted by a collection agency about a medical bill within the past year [3]. Last year, 18% of those with coverage and 43% of the uninsured failed to fill a prescription because of cost, and millions forego routine preventive care like Pap smears, mammograms, and colon cancer screening because of lack of coverage [3]. More than half of 1.748 million American families in bankruptcy courts last year [4] were there at least partly because of medical illness or medical bills; three-quarters of those in medical bankruptcy had health insurance at the onset of the illness that bankrupted them [5].

We advocate a fundamental change in health care financing—national health insurance (NHI)—because we are convinced that lesser measures will fail. Indeed, the alternative to NHI advocated by the Bush administration, so-called Consumer Directed Healthcare (CDH), would actually make matters worse. As discussed in detail below, CDH would financially penalize older and sicker patients, deter millions from seeking needed care, shift additional medical resources to those who are

already well served, further inflate bureaucracy, and do little or nothing to contain costs.

The Failure of Incremental Reforms

Since the implementation of Medicare and Medicaid in the late 1960s a welter of piecemeal reforms have aimed to reduce medical costs and expand coverage. Health maintenance organizations (HMOs) and Diagnosis-Related Groups promised to moderate health spending and free up funds to expand coverage. Tens of billions have been allocated to expanding Medicaid and similar programs for children. Both Medicare and Medicaid have tried managed care. Oregon implemented explicit rationing in its Medicaid program, Hawaii passed a law requiring all employers to cover their workers, Massachusetts passed a similar program in 1988 that was never implemented, Tennessee promised nearly universal coverage under the TennCare program, and several states have implemented high-risk pools to insure high-cost individuals. For-profit firms pledging to bring business-like efficiency to health care now own most HMOs, dialysis clinics, and nursing homes, as well as many hospitals. And, following the prescription of many economists, the health care marketplace has become increasingly competitive. Yet none of these initiatives has braked the relentless rise in the number of uninsured, the costs of care, or the number and power of health care bureaucrats.

All such patchwork reforms founder on a simple problem: expanding coverage must increase costs unless resources are diverted from elsewhere in the system. With US health costs nearly double those of any other nation and rising more rapidly [6], and government budgets already stretched, large infusions of new money are unlikely.

Absent new money, patchwork reforms can only expand coverage by siphoning resources from existing clinical care. Advocates of managed care and market competition once argued that their strategy could accomplish this by trimming clinical fat. Unfortunately, new layers of bureaucrats have invariably overseen the managed care "diet" prescribed for clinicians and patients. Such cost-management bureaucracies have proven not only intrusive but also expensive, devouring any clinical savings. For instance, HMOs in the Medicare program now cost the taxpayers at least 12% more per enrollee than the costs of caring for similar patients under traditional Medicare [7].

Resources seep inexorably from the bedside to administrative offices. The shortage of bedside nurses coincides with the growing number of registered nurse utilization reviewers. Productivity pressures mount for clinicians,

while colleagues who have moved from the bedside to the executive suite rule our profession.

Bureaucracy now consumes nearly a third of our health care budget [8].

Consumer Directed Healthcare, The Next Disappointment

The latest policy nostrum, Consumer Directed Healthcare (CDH), is premised on the idea that Americans are too well insured, painting them as voracious medical consumers too insulated from the costs of their care. CDH proponents advocate sharply higher insurance deductibles (eg, \$5000 for an individual or \$10,000 for a family) as the stimulus needed to make Americans wiser medical consumers. In policy wonks' dreams, these high-deductible policies are coupled with Health Savings Accounts (HSAs), tax-free accounts that can be used to pay the deductible as well as for medical services like cosmetic surgery that are entirely excluded from coverage. But in practice, half of employees covered by CDH plans have no funds at all in their HSA [9], leaving many patients at risk for massive uncovered bills without savings with which to pay them.

CDH plans may benefit those who are young, healthy, and wealthy, but threaten the old, sick, and poor. Under CDH those with low medical expenses win: they get lower premiums, pay trivial out-of-pocket expenses, and perhaps accumulate some tax-advantaged savings in their HSA. But patients needing care lose. For instance, virtually anyone with diabetes or heart disease is sure to pay more under CDH plans. For them, the higher out-of-pocket costs required before coverage kicks in will exceed any premium savings. Even those with only hypercholesterolemia or hypertension will face higher costs unless they forego needed medications or other care.

The CDH incentives selectively discourage low-cost primary and preventive care while doing nothing to reduce the high-cost care that accounts for nearly all health spending. High deductibles will cause many to think twice before opting for a routine mammogram, Pap smear, cholesterol check, or colonoscopy. In the Rand Health Insurance Experiment, the only randomized trial of such health insurance arrangements, high-deductible policies caused a 17% fall in toddler immunizations, a 19% drop in Pap tests, and a 30% decrease in preventive care for men [10]. While the high deductibles caused a 30% drop in visits for minor symptoms, they also resulted in a 20% fall in visits for serious symptoms such as loss of consciousness or exercised-induced chest pain [10]. Most patients have no way to know whether their chest discomfort signals indigestion or ischemia.

CDH discourages many patients from seeking routine, low-cost care, but those with severe acute illnesses have no choice. Even 1 day in the hospital pushes most patients past CDH plans' high-deductible thresholds, leaving the patient with a large bill for the first day of care but with no further incentive to be a prudent purchaser. Hence, CDH incentives inflict financial pain

on the severely ill who account for 80% of all health costs but will have little impact on the overall costs of their care.

Moreover, risk-selection incentives inherent in CDH threaten to raise the cost of other insurance options. As healthy, low-cost patients shift to CDH plans, premiums for the sick who remain in non-CDH coverage will skyrocket. Already in the Federal Employee Health Benefits Program, CDH plans are segregating young men from the costlier female and older workers [11]. According to a leaked memo, Wal-Mart's board of directors considered offering CDH plans to the employees as an explicit strategy to push sicker, high-cost workers to quit [12].

CDH also seems unfair on other accounts. The tax breaks for HSAs selectively reward the wealthiest Americans. A single mother who makes \$16,000 annually would save \$19.60 in income taxes by putting \$2000 into an HSA [13]. A similar mom earning \$450,000 would save \$720 in taxes.

If making Americans pay more out of their pockets for care could constrain health care costs, it would already have done so: the United States already has the world's highest out-of-pocket costs for care and the highest health costs. Co-payments in Switzerland—a nation near the top of the charts in health spending—have not reduced total health expenditures [14]. In Canada, charging co-payments had little impact on costs: doctors less frequently saw the poor (and often sick) patients who couldn't pay, but filled their appointment slots with more affluent patients who could [15, 16]. Higher co-payments for medications in Quebec resulted in increased emergency department visits, hospitalizations, and deaths for the poor and elderly [17]. Similarly, capping drug coverage for Medicare beneficiaries in the Kaiser HMO caused a sharp drop in adherence to drug therapy (as well as a rise in lipids, blood pressure and blood glucose) but no change in overall health costs [18].

Moreover, CDH and HSAs add new layers of expensive health care bureaucracy. Insurers and investment firms are already vying for the estimated \$1 billion annually in fees for managing HSAs [19]. And CDH will force physicians to collect fees directly from patients (many of them unable to pay)—a task that is even costlier than billing insurers [20]—while still making us play by insurers' utilization review and documentation rules: failure to do so disqualifies bills from counting toward the patient's deductible.

Although CDH proponents paint a rosy picture of consumer responsiveness and personal responsibility, CDH would punish the sick and middle-aged while rewarding the healthy and young. Employees would bear more of the burden, employers less. Working families would be forced to skimp on vital care, while the rich would enjoy tax-free tummy tucks. And as in every health reform in memory, bureaucrats and insurance firms would walk off with an ever larger share of health dollars.

The Case for National Health Insurance

In contrast to CDH, a properly structured NHI program could expand coverage without increasing costs by reducing the huge health administrative apparatus that now consumes 31% of total health spending. Health care's enormous bureaucratic burden is a peculiarly American phenomenon. No nation with NHI spends even half as much administering care nor tolerates the bureaucratic intrusions in clinical care that have become routine in the United States. Indeed, administrative overhead in Canada's health system, which resembles that of the United States in its emphasis on private, fee-for-service-based practice, is about half the US level [8].

Our biggest HMOs keep 20%—even 25%—of premiums for their overhead and profit [21]; Canada's NHI has 1% overhead and even US Medicare takes less than 4% [8, 22]. And HMOs inflict mountains of paperwork on doctors and hospitals. The average US hospital spends one-quarter of its budget on billing and administration, nearly twice the average in Canada. American physicians spend nearly 8 hours per week on paperwork and employ 1.66 clerical workers per doctor [23], far more than in Canada [8].

Reducing our bureaucratic apparatus to Canadian levels would save about 15% of current health spending, \$300 billion annually, enough to fully cover the uninsured and to upgrade coverage for those now underinsured. Proponents of NHI [24], disinterested civil servants [25, 26], and even skeptics [27] all agree on this point.

Unfortunately, neither piecemeal tinkering nor wholesale computerization [28] can achieve significant bureaucratic savings. The key to administrative simplicity in Canada and other nations is single-source payment. Canadian hospitals, which are mostly private, nonprofit institutions, are paid a global annual budget to cover all costs, much as a fire department is funded in the United States, obviating the need for administratively complex per-patient billing. Canadian physicians, most of whom are in private practice, bill by checking a box on a simple insurance form. Fee schedules are negotiated annually between provincial medical associations and governments. All patients have the same coverage.

Unfortunately, Canada's program was starved of funds during the 1900s by a federal government that faced budget deficits, reflecting the pressure from the wealthy to avoid paying taxes to cross-subsidize care and other services for the sick and poor. Where once Canadian and US health spending was comparable, today Canada spends barely half (per capita) what we do [6]. Shortages of a few types of expensive, high technology care have resulted.

Yet Canada's health outcomes remain better than ours (eg, life expectancy is 2 years longer), and most quality comparisons indicate that Canadians enjoy care equivalent to that for insured Americans [6, 29]. Moreover, the extent of shortages and waiting lists has been greatly exaggerated. For instance, there are no waiting lists for emergency cardiac surgery, and the median wait for

nonemergency cases is 6 days in Saskatchewan, 24 days in Alberta, and 21 days in Ontario [30]. At present, waits in British Columbia (where the Ministry of Health posts current waiting times at <http://www.hlth.gov.bc.ca/waitlist/cardiac.html>) average 9 weeks for elective cardiac surgery, with five of the province's 24 cardiac surgeons having wait times of 2 weeks or less for elective procedures.

A system structured like Canada's, but with double the funding (ie, the current level of health funding available in the United States), could deliver high quality care without the waits or shortages that Canadians have experienced.

The NHI that we and many colleagues have proposed would create a single tax-funded comprehensive insurer in each state, federally mandated but locally controlled [31]. Everyone would be fully insured for all medically necessary services, and private insurance duplicating the NHI coverage would be proscribed, as is currently the case with Medicare. The current Byzantine insurance bureaucracy with its tangle of regulations and duplicative paperwork would be dismantled. Instead, the NHI trust fund would dispense all payments, and central administrative costs would be limited by law to less than 3% of total health spending.

The NHI would negotiate an annual global budget with each hospital based on past expenditures, projected changes in costs and use, and proposed new and innovative programs. Many hospital administrative tasks would disappear. Hospitals would have no bills to keep track of, no eligibility determination, and no need to attribute costs and charges to individual patients.

Group practices and clinics could elect to be paid fees for service or receive global budgets similar to hospitals. Although HMOs that merely contract with outside providers for care would be eliminated, those that actually employ physicians and own clinical facilities could receive global budgets, fees for service, or capitation payments (with the proviso that capitation payments could not be diverted to profits or exorbitant executive compensation). As in Canada, physicians could elect to be paid on a fee-for-service basis or receive salaries from hospitals, clinics, or HMOs.

A sound NHI program would not raise costs because administrative savings would pay for the expanded coverage. Although NHI would require new taxes, these would be fully offset by a fall in insurance premiums and out-of-pocket costs. Moreover, the additional tax burden would be smaller than is usually appreciated because nearly 60% of health spending is already tax-supported (versus roughly 70% in Canada) [6, 32]. In addition to Medicare, Medicaid, and other explicit public programs, our governments fund tax subsidies for private insurance that cost the federal government alone more than \$188 billion annually [33]. In addition, local, state, and federal agencies that purchase private coverage for government workers account for 24.2% of total employer health insurance spending [34], dollars that should properly be viewed as a public rather than a private health expenditure.

The NHI we propose faces important political obstacles. Private insurance firms and HMOs staunchly oppose NHI, which would eliminate them along with the eight, nine, and even ten-figure incomes of their executives. Similarly, investor-owned hospitals and drug firms fear that NHI would curtail their profits. The pharmaceutical industry rightly fears that an NHI system would bargain for lower drug prices, as has occurred in other nations.

Practical problems in implementing NHI also loom. The financial viability of the system we propose depends on achieving and maintaining administrative simplicity. The single-payer, macro-management approach to cost control, which relies on readily enforceable overall budgetary limits, is inherently less administratively complex than our current micromanagement approach with its case-by-case scrutiny of billions of individual expendi-

tures and encounters. Even under NHI, however, vigilance (and statutory limits) would be needed to curb the tendency of bureaucracy to reproduce and amplify itself.

NHI would reorient the way we pay for care, bringing the hundreds of billions of dollars now squandered on malignant bureaucracy back to the bedside. NHI could restore the physician–patient relationship, offer patients a free choice of physicians and hospitals, and free physicians from the hassles of insurance paperwork.

Patchwork reforms cannot simultaneously address the twin problems of cost and access. CDH is a thinly veiled program to cutback on already threadbare insurance coverage and offers no real hope of cost containment. NHI offers the only viable option for health care reform. We invite colleagues to join with the 14,000 members of Physicians for a National Health Program (www.PNHP.org) in advocating for such reform.

Con

John C. Goodman, PhD

Advocates of single-payer health insurance (SPHI) want third-party payment of all medical bills and they want the payer to be a single, monopsonistic buyer. In layman's terms, they want health care to be free to the patient and they want government to pay all the bills [35].

SPHI, its advocates claim, will control health care spending, eliminate administrative burdens, and leave doctors free to practice medicine without bureaucratic interference. Yet health care is already as “free” to patients in the United States as it is in most other developed countries. The percentage of health care costs paid out of pocket is lower in the United States than in the average Organization for Cooperation and Development (OECD) country [36]. Moreover, government already pays almost half of all US medical bills [37]. Neither the expansion of third-party payment nor the increasing role of government appears to have solved the problems SPHI advocates want solved. Instead, it appears to have made those problems worse.

To understand what SPHI advocates have in mind, we must take a closer look. Doing so leads us to five conclusions:

1. Because of the suppression of normal market forces in all countries, the practice of medicine in the United States is more like medical practice in other countries than it is different.
2. Most other countries have not succeeded in controlling costs any better than the United States has; but where they have succeeded, it is primarily because of health care rationing.
3. Canadian-style medicine does not require government; large companies could implement such a system on their own.

4. Much of the allure of national health insurance stems more from widely believed myths rather than a true understanding of how such systems work.
5. True reform consists not in substituting one third-party payer for another but in liberating doctors and patients from the very problems created by third-party payment as such.

Similarities Among Health Care Systems

Normal market forces in health care have been systematically suppressed throughout the developed world. As a result, both patients and doctors are being denied many of the benefits of competitive markets.

Horse and Buggy Medical Practice

Although medical science has progressed by leaps and bounds, the way doctors relate to their patients has changed little during the past 100 years. Sometime in the early 20th century, lawyers, accountants, and most other professionals discovered that the telephone was a useful instrument for communicating with clients. Yet even today, consultations with doctors by telephone are quite rare. Sometime in the late 20th century, most other professionals discovered e-mail. Yet only 21% of patients exchange e-mail with their physicians; of these, slightly more than 2% do so on a frequent basis [38].

One would be hard-pressed to find a lawyer in the United States today who does not keep client records electronically. Ditto for accountants, architects, engineers, and those in virtually every other profession. Yet although the computer is ubiquitous and studies show that electronic medical record (EMR) systems have the capacity to improve quality and greatly reduce medical

errors [39], no more than one in five physicians or one in four hospitals have such systems [40]. Canada, incidentally, is behind the United States in the adoption of EMRs, although several European countries have recently invested heavily in information technology [41].

Defective Payment Schemes

Why has the practice of medicine (as opposed to the science of medicine) changed so little in the modern era? The reason is because of the way we pay for medical care, particularly the way we pay doctors. Both in the United States and in Canada, patients "pay" for care primarily with their time, not with money, while third-party payers pay physicians by task.

Consequences of Rationing by Waiting

One consequence of rationing by waiting is that the time of the primary care physician is usually fully booked, unless the physician is starting a new practice or working in a rural area. As a result, there is very little incentive to compete for patients the way other professionals compete for clients. Because time—not money—is the currency we use to pay for care, the physician does not benefit (very much) from patient-pleasing improvements and is not harmed (very much) by an increase in patient irritations. Bottom line: When doctors and hospitals do not compete on the basis of price, they do not compete at all.

Consequence of Paying by Task

At last count, there were about 7500 specific tasks Medicare pays for. Telephone consultations are not among them. Nor are e-mail consultations or electronic record keeping. What is true of Medicare is also true of most private insurers. In general, when third parties pay by task, there will always be valuable services not on the list of reimbursable activities. Physicians thus have an incentive to perform those tasks for which there is payment and avoid those tasks for which there is no payment.

Effects on the Chronically Ill

Because the chronically ill need more interactions with their doctors, they face above-average waiting costs. This may be one reason why so many are not getting the one thing they most need from a primary physician and the thing that is most likely to prevent more serious and costly health problems later on: a prescription [42]. The ability to consult with doctors by telephone or e-mail could be a boon to the chronically ill. Face-to-face meetings with physicians would be less frequent, especially if patients learned how to monitor their own conditions and manage their own care. Yet these changes are unlikely until we begin to pay doctors the way other professionals are paid.

Differences Among Health Care Systems

On paper, the United States spends more on health care per capita than other developed countries. But the

real social cost of health care is not measured in terms of cash outlays, it is measured in terms of real resources used. Surprisingly, there are fewer practicing physicians and nurses and acute care bed days per capita in the United States than the average OECD country. Moreover, even measured in terms of dollars spent, the annual rate of growth in real per capita spending on health care in the United States during the past 40 years is roughly equal to the OECD average [43].

To the degree that countries have better controlled their spending, however, it has nothing to do with greater efficiency. Other countries do not have the US tort system. And in foreign bureaucratic systems, there are fewer questions to answer, fewer forms to complete, and fewer regulations to follow. However, the two most powerful weapons of cost control are the use of the monopsonistic buying power of the state and health care rationing.

Monopsonistic Buying Power

In other developed countries, governments use their buying power to force providers to accept below-market reimbursement, just as Medicaid and Medicare do in the United States. For instance, the income of a physician is 5.5 times that of the average worker in the United States, on average. The ratio for Germany and Canada is 3.4 and 3.2, respectively. The comparable ratio is 1.5 in Sweden and 1.4 in the United Kingdom [44].

On paper, lower physician fees appear to lower to a country's cost of care. Yet monopsonistic buying power does not lower the real social cost of health care, it shifts those costs. A different way of achieving the same result would be to pay doctors market-determined fees and then impose a special tax on them, leaving their net income where it is today. The virtue of this alternative approach is that it would be clearer that social costs have not been lowered, they have merely been shifted to the providers of care.

Rationing Care

By far the most common way of curtailing costs in other countries is by limiting resources available to hospitals and doctors and forcing them to ration care. One technique, used in Canada, Britain, and New Zealand, is the global budget. Health authorities are only allowed so many dollars to spend, regardless of the amount of sickness. Another method is technology control. Britain has less than one-half as many computed tomography (CT) scanners per capita as the United States and only one-half as many magnetic resonance imaging (MRI) scanners. The United States has two-thirds more CT scanners per capita than Canada and more than three times as many MRI units [45]. At last count, there were only three positron emission tomography (PET) scanners available for routine use in Canada's Medicare system, compared to more than 1000 in the United States [46, 47]. To believe

that quality of care is the same in the two countries one must basically argue that PET scanners do not matter.

The Canadian System Without Government

Advocates of SPHI invariably imply that government payment of all medical bills is the key to achieving the goals they pursue. But having a single payer of all medical bills is neither a necessary nor a sufficient condition to achieve those goals. If shifting part of the cost of the health care system onto providers is a social goal, government can simply tax doctors. If a more rational tort system is the goal, we do not need a single payer for that either. If rationing of medical technology is the goal, simply license and regulate the supply of medical technologies. We do not really need government either. Large companies and their employees are free to adopt a Canadian-style health care plan on their own. For example, the auto workers could form their own health maintenance organization (HMO) and give it, say, 75% of what auto workers now spend on health care. The HMO managers could be instructed to ration care just the way Canadian doctors do [48].

Myths About National Health Insurance

An enormous mythology has developed about health care in other countries. Let us set the record straight.

MYTH: HEALTH CARE IS A RIGHT. Although virtually every country with national health insurance has proclaimed health care to be a basic human right, no country has ever established such rights. Citizens of Canada, for example, have no right to any particular health care service. They have no right to an MRI scan. They have no right to heart surgery. They do not even have the right to a place in line. The 100th person waiting for heart surgery is not entitled to the 100th surgery. Other people can and do jump the queue.

Far from guaranteeing health care as a right, other countries routinely impose health care rationing that delays or denies needed care. At last count, more than 786,000 people were on hospital waiting lists in England [49], and about 771,000 in Canada are waiting for treatment of all types [50].

According to the World Health Organization (WHO), as many as 25,000 people in Britain die of cancer each year because they cannot obtain the latest cancer treatments [51]. Less than one-third of British patients who have a myocardial infarction receive beta-blockers (used by 76% of patients in the United States), despite the fact that use of the drug after a heart attack reduces death by 20% [52].

Perhaps as a result of not receiving the care they need, people with curable diseases often do not survive. In the United States, only one in four of those diagnosed with breast cancer dies of the disease, compared with one in three in Germany and France, and almost one in two in New Zealand and the United Kingdom. In the United States, only one in five prostate cancer patients dies of the disease, compared to

one in four in Canada, one in two in France, and more than half in the United Kingdom. [53].

MYTH: NATIONAL HEALTH CARE IS EFFICIENT. A widely used measure of hospital efficiency is average length of stay. By this standard, US hospitals are ahead of their international counterparts. The average length of hospital stay in the United States is 5.9 days compared with 6.2 days in Australia, 9.0 in the Netherlands, and 9.6 in Germany.

Although thousands are waiting for medical treatment, about 16% of British hospital beds are empty on any given day, and as many as 15% are filled with patients who do not belong in a hospital at all [54, 55]. Thus, up to one-third of hospital beds are unavailable for acute care patients!

A comparison of the British National Health Service and Kaiser Permanente, a US HMO, concluded that the per capita costs of the two systems were similar. However, Kaiser provided its members with more comprehensive and convenient primary care services and much more rapid access to specialists and hospital admissions [56].

MYTH: SOCIALIZED CARE IS EQUAL CARE. Despite the promise of equal care for all, inequalities pervade every government-run health care system [57–59]. In the United Kingdom, people from poor urban areas live shorter lives and die more frequently from common, treatable illnesses than their wealthier neighbors [60]. Vast inequalities also exist in Canada. Among the 29 health regions in British Columbia, there is a five-to-one difference in the per capita services of internists and a 31-to-one difference in the services of psychiatrists [61]. The Inuits and Cree in Canada, the Maori in New Zealand, and the Aborigines in Australia appear to get less care than the majority ethnic groups, and the inequalities appear at least as great or greater than racial disparities in the United States [62].

MYTH: NATIONAL HEALTH INSURANCE WOULD MAKE US PRODUCTS MORE COMPETITIVE. An oft-repeated claim is that health care adds \$1500 to the price of each General Motors car produced in the United States, whereas a General Motors plant in Canada has no such cost [63]. This is not an empirical finding. It is simply bad economics. Health care does not add anything to the cost of an automobile—in America or anywhere else in the world. In the United States, employer-provided health insurance is part of the total compensation of workers [64]. As such, it substitutes for wages. Higher health care costs do not add to labor costs, they reduce take-home pay for workers who choose health care instead of the wage equivalent—just as taxes in Canada reduce Canadian workers' take-home pay.

MYTH: WE CAN HAVE THE GOOD WITHOUT THE BAD. The problems described above are not accidental byproducts of government-run health care systems. They are the

natural and inevitable consequences of placing the market for health care under the control of politicians.

Take, for example, the tendency to over-provide care to patients with minor ailments. In a typical US private health care plan, 40% of health care dollars are spent on the sickest 2% of the population [65]. In a political system, politicians cannot afford to spend 40% of the budget on 2% of the voters, many of whom are probably too sick to vote anyway. The temptation is always to take from the few who are sick and spend instead on the many [66].

Health Markets Without Third-Party Payers

In health care markets where third-party payers do not negotiate the prices or pay the bills, the results are radically different. Entrepreneurs in these markets compete for patients by offering greater convenience, lower prices, and innovative services unavailable in traditional clinical settings. Until recently, such markets were confined to the types of procedures health insurance does not cover at all, such as cosmetic surgery and vision correction surgery. Today, competitive markets are emerging outside the third-party payment system, covering services ranging from primary care to major surgery.

Health care markets without third-party payers typically resemble competitive markets for other goods and services far more than they resemble conventional health care markets. In particular, they tend to have three characteristics:

- Unlike managed care, pay-for-performance and other demand-side initiatives, innovations in these markets invariably originate on the supply side.
- In the absence of third-party payment, providers are free to package and price—and repackage and reprice—their services, to meet patient needs.
- Providers in these markets compete for patients based on price and quality.

What follows are some notable examples [67].

COSMETIC SURGERY. Unlike most other forms of surgery, patients in this market can typically find a package price in advance covering all services and can compare prices before surgery. The number of procedures has grown sixfold during the past decade and a half, and the market has seen numerous technological innovations of the type that are blamed for rising costs for other surgical procedures [68], yet the real price has declined [69].

LASIK SURGERY. Here too, patients can find package prices and they can compare prices. During the past decade, the real price has fallen by 30%. Patients can also get quality information, and unlike most other surgery markets, higher-quality services command a premium. Patient satisfaction is 93% and is even higher for higher-quality providers [70].

RETAIL WALK-IN CLINICS. Walk-in clinics are small health care centers located inside shopping malls, big-box retailers, or in storefronts in strip shopping centers. They are staffed by nurse practitioners and offer a limited scope of services but added convenience. MinuteClinic, the pioneer of the concept, allows shoppers to get routine medical services such as immunizations and strep tests. No appointment is necessary, and most office visits take only 15 minutes. MinuteClinics clearly list prices, which are often only half as much as a traditional medical practice. Quality is comparable with traditional practices and there is less variance [71]. Medical records are stored electronically and prescriptions can also be ordered that way.

TELEPHONE CONSULTATIONS. TelaDoc Medical Services, located in Dallas, is a telephone-based medical consultation service that works with physicians across the country. Consultations are available around the clock. Calls are usually returned within 30 to 40 minutes. The physician can access the patient's medical history online, e-mail a prescription to a pharmacy, and add information to the patient's EMR [72].

CASH-FRIENDLY PRACTICES. PATMOS EmergiClinic, in Greenville, Tennessee, represents a growing trend toward cash-only practices. Founded by physician Robert S. Berry, it is a walk-in clinic for routine minor illnesses and injuries and is open mornings Monday through Saturday and some afternoons by appointment. Established patients are occasionally treated by phone consultation. The clinic uses EMRs and its physicians prescribe drugs electronically. Most EmergiClinic patients do not have insurance, and physicians in traditional medical practice are often reluctant to see them.

CONCIERGE DOCTORS. An estimated 300 to 400 doctors nationwide now practice concierge or boutique medicine. The annual fee can be as low as \$1500, although some charge as much as \$15,000. In return, patients get same-day or next-day appointments, very little waiting, much more personal service, and a portable, credit-card-sized EMR. They also get their doctor's cell phone number and the right to call or page day or night. Under the most expensive options, some doctors make house calls, deliver medications, or accompany the patient to see a specialist [73].

MEDICAL TOURISM. Increasingly, cash-paying patients are traveling outside the United States for surgical procedures. Facilities that cater to such medical tourists typically offer (1) package prices that cover all the costs of treatment, including physician and hospital fees, and sometimes airfare and lodging as well; (2) an EMR; (3) low prices that are often one-fifth to one-third the cost in the United States; and (4) high-quality care in facilities, and by physicians, that meet American standards [74, 75].

Lessons for Reform

In those health care sectors where third-party payment is rare or nonexistent, markets are vibrant, entrepreneurial, and competitive. By contrast, where third-party payment is the norm, markets tend to be bureaucratic and stifling, and doctors and hospitals rarely compete for patients on the basis of price or quality.

In markets where out-of-pocket pay is standard, there are systematic rewards for producing high-quality, low-cost care. Yet in markets where third-party pay is the norm, excellence tends to be distributed randomly and is often the result of the energy and enthusiasm of a few individuals rather than the result of any financial incentives.

Research by John Wennberg and colleagues at Dartmouth Medical School suggest that if everyone in America went to the Mayo Clinic for health care, our annual health care bill could be lowered by 25% (more than \$500 billion!) and the average quality of care would improve. If everyone got care at Intermountain Healthcare in Salt Lake City, our health care costs could be lowered by one-third [76].

Of course, not everyone can get treatment at Mayo or Intermountain. But why are these examples of efficient, high-quality care not being copied and replicated all across the country? The answer must surely be: high-quality, low-cost care is not financially rewarding. Indeed, the opposite would appear to be true. How can we reverse these incentives? Three sets of changes would be desirable.

Encouraging Individual Self-Insurance

The alternative to third-party insurance is individual self-insurance through a dedicated savings account. Since Health Savings Accounts (HSAs) became available in 2004, they have become the fastest-growing product in the health insurance marketplace. Currently, 7.2 million people have them and another 6.2 million have Health Reimbursement Arrangements (HRAs), a similar concept [77].

These accounts allow patients to manage some of their own health care dollars. But as currently designed, they tend to piggyback on third-party payer arrangements rather than serve as a fundamental challenge to the current system. A better design would be to carve out entire categories of care, such as most primary care and most diagnostic tests, and have patients pay directly for such services. More generally, patients should always be encouraged to self-insure for those services for which it is both appropriate and desirable for patients to exercise individual discretion [78].

Reward Entrepreneurship

Under the current system, Medicare and Medicaid stifle entrepreneurial activity and financially punish efforts to lower costs or improve quality. Why can't these agencies reward improvements instead? Suppose an entrepreneur offered to replicate the Mayo

Clinic in other parts of the country, thus potentially saving Medicare 25% of costs and improving quality of care along the way. Medicare should be willing to pay 12.5% more than its standard rates to achieve twice that amount in lower total costs. That would leave the entrepreneur with a 12.5% additional profit, an amount one would hope that would encourage other entrepreneurs to enter the market with even better ideas. Once government agencies jump-start the entrepreneurial process in this way, private insurers are likely to follow suit.

Remove Distortions in the Third-Party Insurance Market

We need four reforms that will radically change the nature of health insurance and make it more like life insurance, casualty insurance, and other market-based insurance products [79]. First, we need to make sure that being privately insured is just as attractive as being uninsured. At a minimum, this means that the dollars currently being used to fund charity care are available to subsidize private insurance instead. This is the core idea behind Governor Romney's reform in Massachusetts [80]. The idea is also endorsed in President Bush's State of the Union health care proposal [81].

Second, we need just as much encouragement for private insurance as there is for public insurance through Medicaid or the State Children's Health Insurance Program. Under the current system, every extra dollar spent on Medicaid reduces private insurance by 50 to 75 cents [82]. The correction is to make Medicaid dollars available as subsidies for private insurance.

Third, we need just as much encouragement for individually owned, personal, and portable insurance as there is for nonportable, employer-specific insurance. The current tax law heavily subsidizes the latter and meagerly subsidizes the former [83].

Fourth, there should be just as much encouragement for individual self-insurance through health savings as there is for third-party insurance. Indeed, we would not need to encourage self-insurance, as recommended above, if the playing field were level. The market would find the right allocation between the two [84].

Conclusion

On the surface, SPHI appears to be a radical reform. In reality, all the advocates have in mind is substituting one version of third-party payer for others. Under one proposal, for example, everyone would be enrolled in Medicare [84]. Yet in most places Medicare is administered by Blue Cross. To believe that Medicare (managed by Blue Cross) would be substantially better than a private Blue Cross policy (managed by Blue Cross) strains credibility. Indeed, without mandatory rationing, technology controls, and below-cost reimburse-

ment fees, there would be very little difference between SPHI and what we have today.

To get truly radical reform, we need to challenge the entire third-party payment system. Truly radical reform, in other words, would liberate doctor-

entrepreneurs to meet patient needs in innovative ways, free patients to become smart shoppers, and allow a competitive medical marketplace to allocate resources, while raising quality and lowering cost in the process.

Concluding Remarks

Robert M. Sade, MD

David Himmelstein and Steffie Woolhandler agree with John Goodman on some important points. Our health care system is badly broken and needs to be fixed, and incremental fixes have only made things worse. Beyond those points of agreement, their visions diverge sharply, with each camp looking at the causes of dysfunction through a different lens and proposing vastly different approaches to health care reform.

Himmelstein and Woolhandler review the rise of health care costs and paints a bleak picture for the near future. Current trends will eventually lead our health care system into bankruptcy. Piecemeal attempts at market reforms, such as Health Savings Accounts, have not solved any problems and, in their view, neither will consumer-driven health care.

The solution to this vast set of problems, in their view, is a single-payer national health insurance (NHI) system, in which everyone has the same health care coverage. By centralizing funding, hundreds of billions of dollars currently squandered annually on a malignant bureaucracy will be used instead to pay for health care. The patient-physician relationship will be restored, patients will choose physicians and hospitals freely, and physicians will have no insurance paperwork.

Goodman agrees that incremental reform has made things worse, but he sees third-party interventions in the provision of health care to be the culprit. In this regard, the United States is more similar to other countries around the world than it is different. Other countries have not succeeded in controlling costs any better than the United States, despite having single-payer systems. The appeal of NHI is bolstered by myths about how such systems function: national health care is efficient, health care is a right, and socialized health care is egalitarian, among other myths.

The solution to these problems is to dislodge third-party payers from health care markets. At its root, Goodman argues, single-payer health insurance has only the appearance of radical reform but, in reality, merely substitutes one version of a third-party payer for another. Radical reform requires challenging the entire third-party payment system through free market reforms.

The political process required to extricate the US health care system from its severe dysfunction will be extremely complex and will not arrive easily at a clear end point. Much more is at stake in that process than health care

delivery; the philosophical road we choose to travel has enormous implications for the future structure and function of American society. Most discussions of health care system reform, including these two essays, pay little attention to the ethical foundations that underlie different approaches to health care system reform. President Clinton recognized the importance of ethical justification for reform when he created a committee of ethicists to describe the ethical principles underlying his 1993 Health Security Act. We agree with his appreciation of the importance of philosophical foundations and recognize that competing programs may have radically different foundations. We describe the spectrum of ethical foundations for health care system reform in an accompanying editorial [85].

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