

## Health Care – What is the Problem

Words have meaning and medicine is a very precise language. Health care is the maintenance and improvement of physical and mental health. A crisis implies imminent danger or threat. In January 1994, President Clinton made a speech declaring a health care crisis. You cannot have a health care crisis that goes on for years. Inflating the rhetoric only adds to misinformation. What we actually have is a health care cost problem. For many years the rate of inflation of medical expenses has exceeded the consumer price index by 2 to 4% annually. Since 2004 the rate of increase has slowed, but still exceeded inflation. Private health insurance premiums grew 5.8% in 2007 which is much lower than the 9.1% peak of 2002. The Center for Medicare and Medicaid Services projects spending of over \$2.48 trillion on health care in 2009, or \$8,369 per US resident. Growth in the National Health Expenditure is expected to average 6.2% per year over the projection period (2008-2018). The health expenditure share of GDP was 16.2% in 2007 and is projected to reach 20.3% by 2018. Medicare spending is projected to average 7.3% growth per year over the projection period. Medicaid spending is projected to average 8.4% growth per year over the projection period. Private spending is projected to average 5.3% growth per year over the projection period.<sup>1</sup>

In most Western industrial democracies, health care systems shaped by government policies have evolved through stages. From the end of World War II through the mid-1980s, Americans paid for hospital care primarily through a cost-plus system of health care finance. Health insurance literally ensured that hospitals had enough income to cover their costs and health insurers acted as agents not for policyholders, but for the suppliers of medical services. Because the only way the suppliers could increase their incomes was to increase costs, the cost-plus system invariably led to rising health care costs. Patients had no reason to show restraint, since they were spending someone else's money, not their own.

Because there is a limit to how much any society will pay for health care, the cost-plus system was ultimately forced to limit the decisions of suppliers of medical care in arbitrary ways. The limitations took the form of rules and restrictions written by impersonal bureaucracies, far removed from the doctor-patient relationships they sought to regulate. During the 1980s, the health care system evolved from a pure cost-plus system into a cost-control phase in which third party paying institutions, both public and private, attempted to reduce its share of the total cost. This becomes a bureaucratic warfare over shifting costs. Third-party payers seek to eliminate waste by controlling price, or quantity, or both.

For the majority of physicians, Medicaid reimbursement is significantly less than the cost of providing care, Medicare is slightly lower or equal to the cost of providing care, and private insurance reimbursement is more than the cost of providing care. This results in cost shifting to be able to provide care for those on government plans. Medicare is the 800 pound gorilla sitting in the room. Medicare sets reimbursement rates for all types of procedures and office visits. Insurance companies simply follow Medicare's lead with reimbursement rates that are a multiple of Medicare rates. The reimbursement rates from insurance companies generally range from 110 to 140% of Medicare rates. Once Medicare reimburses for a particular

procedure or device, like motorized scooters, there is an incentive to qualify as many people as possible. Medicare gives more emphasis to procedures relative to office visits. The Medicare reimbursement for removing a toenail is more than three times the reimbursement for an office visit to control a patient's blood pressure. Physicians are incentivized to do things to patients rather than maintain a patient's health.

All free market competitive systems have two characteristics in common: increasing quality and decreasing prices. Examples include cell phones, computers, cameras and music players (MP3, iPod). 20 years ago cell phones were large and bulky, limited in their features and were very expensive. Today's smart phones are compact, have multiple applications and are relatively inexpensive. There are two areas of health care where quality has increased and price has decreased: plastic surgery and corrective eye surgery (Lasik). This has occurred because the individual consumer pays for the entire bill. When you have a third-party, paying for the majority of any particular expense, there is no incentive for the individual consumer to control costs. It is a common practice for consumers to demand additional costly and sometimes unnecessary testing and procedures once their annual deductible has been met. It is also common to delay elective surgeries until it is covered by insurance. These practices increase the cost of medical care. In many respects health insurance is not insurance at all. It is instead prepayment for the consumption of medical care. Do we continue with a cost-plus health care system that rations care or do we make a fundamental change to a market based competitive system.

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<sup>1</sup> [www.cms.hhs.gov](http://www.cms.hhs.gov); National Health Expenditure data.

## Health Care – Government Run System

In 2008 when then Senator Obama was a presidential candidate, his health care plan specifically mentioned the Public Plan. President Obama's idea of a public plan is to force all reimbursements down to Medicare rates. That is his idea of controlling costs. His plan was inadvertently revealed by Larry Summers, the Director of the National Economic Council, when he gave a speech on C-SPAN before The Economic Club of Washington at their April meeting. He was asked a question about the size of the US deficit. Part of his answer included the following:

“That’s why health care reform is so important because a large fraction of the federal budget is health care and if health care spending is growing 3 to 4 percent a year faster than the rest of the economy then there is no way that the federal budget can be under control. And if you try to control federal spending without controlling overall health spending you know what’s going to happen, the people in the federal programs aren’t going to be able to.” And then he stopped and paused before continuing, “The health care system isn’t going to want to serve the people in the federal programs. That’s why the health care agenda is crucial to the long term financial sustainability agenda.” When he talks about overall health spending he is referring to both the government and private insurance reimbursement to physicians and hospitals. Medicare and Medicaid have lower reimbursements than private insurance. Now let me complete his sentence, "and if you try to control federal spending without controlling overall health spending you know what’s going to happen, the people in the federal programs aren’t going to be able to FIND A DOCTOR.” Physicians are already closing their practices to Medicare and Medicaid patients because reimbursements will not cover their costs of providing care.

The Physicians’ Foundation conducted a survey between May and June 2008. It was mailed to 270,000 primary care doctors and more than 50,000 specialists. The total number of responses received was 11,950. Declining reimbursement rated highest on the list of issues physicians identify as impediments to the delivery of patient care in their practices, followed by demands on physician time. 82% said their practices would be unsustainable if proposed cuts to Medicare reimbursements were made. 65% said Medicaid reimbursement is less than their cost of providing care and 36% said Medicare reimbursement is less than their cost of providing care. Over 33% of physicians have closed their practices to Medicaid patients and 12% have closed their practices to Medicare patients.<sup>1</sup>

Some groups are promoting the Medicare system as a model for a single-payer system. Medicare is not really a true insurance plan. It does not negotiate with providers. It collects premiums almost exclusively by deductions from Social Security payments. It sets national provider reimbursement rates and pays 99.9% of all claims without serious scrutiny to almost any licensed provider. In fact most of its claims are handled through contracts with private insurers. Comparing the administrative costs of Medicare (3%) to the administrative costs of private insurance (10-20%) is like comparing apples to oranges. Medicare spends no money on collecting revenue. Private insurers must build provider networks and exclude low quality providers. Medicare is forbidden from excluding poor quality providers. Private insurers must

negotiate rates. Medicare just fixes prices using a statutory and regulatory scheme. Private insurers must cover marketing costs. Medicare has no marketing costs. Medicare does not include the cost of the buildings it uses. Profit is not part of its administrative costs as it is in private insurance. One of the main reasons Medicare's administrative costs are low as a percentage of its overall spending is that it fails to control both wasteful spending and fraud. Medicare spends less than one-fifth of 1% on anti-fraud measures.<sup>2</sup> Some estimates of the wasteful spending and fraud in Medicare are 30%. Medicare does not classify payments as fraud; instead they use the term payments "in error." By Medicare's own admission their in error payments in 2007 were almost 10% of their total payments. The worse Medicare performs, the better its ratio of total spending to administrative costs appears; and the less it spends on administration, the worse it performs. For example, assuming that fraud levels are 10% of payments after spending 5% on administration, and in private plans fraud levels were reduced to 5% of payments after spending an extra 1% on administrative costs for effective fraud prevention, Medicare seemingly spends \$5 but actually spends \$15 (\$5 in administrative costs and \$10 in fraud), while the private plan spends \$11 (\$5 plus \$1 plus \$5 lost to fraud) for the same \$100 of delivered care.

The grass is not always greener on the other side of the Atlantic or north of the border. In a recent Forbes.com commentary, David Gratzer noted that critics insist that the privately dominated American health care system has seen greater cost increases than public health care systems abroad. And, historically, that's true. But health care has changed, and costs are rising worldwide without regard to each nation's health insurance model. In 2007, the Kaiser Family Foundation used Organization for Economic Co-Operation and Development (OECD) data to show that the growth of American health care spending slowed considerably in recent years. Between 1990 and 2003, America's per capita health care inflation was 3.6% (less than in the 1980s). America's "spiraling health costs" were in fact comparable to growth in France and Iceland, and even lower than many countries, including Australia, Belgium and Britain. OECD data confirms that the trend continues through this decade, with American health spending increases being about the average for OECD countries (average 2000-2006: U.S. 4.95; OEDC average 4.9). And public systems continue to spill red ink; even with pharmaceutical price controls and rationing, limited access to technology, and minimal capital investments, Ontario's health budget is projected to grow by 16.5% over the next three years. Quebec's annual health inflation rate is almost 6%. In Britain, the NHS reports a 60-year *average* increase of 3% over inflation. Ireland's single-payer system has experienced constant price turbulence. Despite 4.7% *deflation* this May, Irish health costs still grew at an annualized rate of 3.5%.<sup>3</sup>

A common criticism of the U.S. system is based on the World Health Organization (WHO) ranking of overall health system performance for the member countries. The US ranked 37<sup>th</sup> while most European countries and Canada had a higher ranking.<sup>4</sup> This ranking included numerous variables other than health outcomes. One way to directly measure health outcomes is to look at the five-year cancer survival rate. The five-year survival rates for all cancers for men are: U.S. 66%, Europe 47%; and for women are: U.S. 63%, Europe 56%. Results are similar for Canada. In the US, 85% of women aged 25 to 64 years have regular Pap smears, compared with 58% in Great Britain. The same is true for mammograms; in the US,

84% of women aged 50 to 64 years get them regularly – a higher percentage than in Australia, Canada or New Zealand, and far higher than the 63% of British women.<sup>5</sup>

<sup>1</sup> [www.physiciansfoundation.org](http://www.physiciansfoundation.org)

<sup>2</sup> Wall Street Journal, “Is Government health Insurance Cheap?” April 14, 2009.

<sup>3</sup> [www.forbes.com/2009/07/24/obama-administration-health-care-costs-opinions-contributors-david-gratzer\\_print.html](http://www.forbes.com/2009/07/24/obama-administration-health-care-costs-opinions-contributors-david-gratzer_print.html)

<sup>4</sup> [www.who.int/healthinfo/paper30.pdf](http://www.who.int/healthinfo/paper30.pdf)

<sup>5</sup> US Cancer Care Is Number One; National Center for Policy Analysis; No. 596, October 11, 2007.

## Health Care – Market Based Competition

So what can be done to help control the growth of health care costs? The problem is the 800 pound gorilla in the room, Medicare. Medicare does not encourage competition. There must be a fundamental shift away from a cost-plus payment system to one in which the consumers are in control. The solution must include market based competition.

The YOUNG Conservatives of America ([www.tycoa.com](http://www.tycoa.com)) have developed a comprehensive conservative platform including a plank on health care.

The basis of the United States Constitution and our unique American culture is freedom. This fundamental belief expressed in the Declaration of Independence includes Life, Liberty and the Pursuit of Happiness.

Americans have always prospered when they have been given the freedom to become active and productive citizens. We believe a capitalistic, free, open market system provides the maximum benefit for all citizens. Health care must follow this same pattern.

We believe health care should be a patient centered, consumer based system where every individual has the freedom to choose the type of health care that is best for him or her. Along with this freedom comes personal responsibility in the individuals' health care choices.

This patient centered, consumer based system has six key principles.<sup>1</sup>

- #1: Individual consumers are the key decision makers in the system.
- #2: Individuals buy and own their own health insurance coverage.
- #3: Individual consumers choose their own health insurance coverage.
- #4: Individuals have a wide range of coverage choices.
- #5: Prices are transparent to consumers.
- #6: Consumers have regular opportunities to make coverage changes on predictable terms.

We do not believe health care is a right. A right is defined as those areas of life wherein government has guaranteed us that it will not stop us from acting within a narrow scope of opportunity. A right, as mentioned in the United States Constitution, is a right to an action. Health care consists of goods and services. Also, rights do not confer an obligation on other individuals.

We believe the role of the federal government should be empowering citizens to obtain their own health insurance coverage, not acting as an insurance company, setting prices and defining coverage limits. The current federal tax deduction given to companies for health care expenses should be eliminated. Instead, the federal government should use the additional tax revenue to provide vouchers

to low income individuals and families; thus putting the decision making and responsibility in the hands of the individual consumer and his or her family.

Current federal and state insurance mandates and regulations act as an impediment to increased competition among insurance companies. We believe mandates and regulations should be kept to an absolute minimum in order to increase competition, increase quality and lower prices.

The current system of physician reimbursement is not designed to promote health. The federal and state governments should encourage insurance companies to work with physicians on innovative payment methods that do promote health and quality.

Continuing the same system will not reduce costs and moving to a single payer system will not improve quality. The best solution is less government involvement and more competition. All health care systems ration care. The question you need to ask is, "Do you want to make your medical decisions about what you spend on health care with money that you control, or do you want the decisions to be made by a bureaucrat?"

<sup>1</sup> Health Care Reform: Design Principals for a Patient-Centered, Consumer Based Market – Edmund Haislmaier, The Heritage Foundation April 23, 2008.