Part VI

Dismantling the Cost-Plus System

19. The International Trend toward Privatization of Health Care

Throughout the 1980s, political change around the world communicated a simple message: Free markets based on individual pursuit of self-interest work, whereas collectivism and bureaucratic decisionmaking do not. The 1980s were the decade of privatization, capped by the dramatic and continuing collapse of communist regimes. Health care proved to be no exception:

- In 1989, the British government introduced radical market-based reforms in health care and began to allow private hospitals to compete against public hospitals for National Health Service (NHS) funds.[1]
- In 1987, the Netherlands introduced a voucher system that allows consumers to choose among private and public insurance funds.[2]
- In 1987, West Germany introduced a new policy which encourages competition among hospitals.[3]
- More recently, the government of New Zealand has signaled its intent to end 40 years of socialized medicine by giving people tax incentives to purchase private health insurance and by introducing market-based reforms in the public sector.[4]
- Sweden, along with other European countries, has already introduced some "managed competition" into its national

[1]See Patricia Day and Rudolf Klein, "Britain's Health Care Experiment," *Health Affairs* (Fall 1991), pp. 39–59; and Alain C. Enthoven, "Internal Market Reform of the British Health Service," *Health Affairs* (Fall 1991), pp. 60–70.

[2]Jeremy W. Hurst, "Reforming Health Care in Seven European Nations," *Health Affairs* (Fall 1991), pp. 18–19.

[3]Ibid., p. 18.

[4]A blueprint for the reforms may be found in Patricia Danzon and Susan Begg, *Options for Health Care in New Zealand* (Wellington: New Zealand Business Roundtable, 1991).

health insurance system; and with the 1991 change of government, those reforms will undoubtedly continue.[5]

- In Canada, pressures are mounting to allow private health insurance options and to institute user fees, and Claude Castonguay, considered the father of Quebec's health care system (the oldest government health insurance scheme in Canada), has called for privatization and competition in the supply of health services.[6]
- The Soviet Union's new health care reform plan calls for decentralization, "enterprise," and the introduction of financial incentives into health care.[7]
- Chile has given its citizens financial incentives to opt out of national health insurance for the last decade, and most other Latin American countries are seeking ways to partially privatize their health care systems.[8]

Yet privatization of health care has proved far more difficult than privatization of state-owned enterprises. Among developed countries, even Britain (which pioneered the international privatization revolution) and New Zealand (which made greater strides toward economic liberalization than any other noncommunist country) have met fierce political resistance over proposals to introduce market-based health care reforms. Among less-developed,

[5]Commenting on the change, one news report noted that "Swedes have had to wait for years for cataract and other operations, and some have died awaiting heart bypass surgery." See Steven Prokesch, "Socialists Suffer Major Defeat in Swedish Vote," *New York Times*, September 16, 1991. For general changes in Europe, see the discussion in Bengt Jönsson, "What Can Americans Learn from Europeans?" Symposium: International Comparisons of Health Care Systems, *Health Care Financing Review*, 1989 Annual Supplement, pp. 79–93.

[6]See Clyde H. Farnsworth, "Economic Woes Force Canada to Reexamine Medical System," *New York Times*, November 24, 1991; and Edward Neuschler, *Canadian Health Care: The Implications of Public Health Insurance* (Washington: Health Insurance Association of America, 1989), p. 52.

[7]See Diane Rowland and Alexandre V. Telyrikov, "Soviet Health Care from Two Perspectives," *Health Affairs* (Fall 1991), pp. 71–86.

[8]For a description of Chile's health care reforms, see John C. Goodman and Peter A. Ferrara, "Private Alternatives to Social Security in Other Countries," NCPA Policy Report no. 132 (Dallas: National Center for Policy Analysis, April 1987); and Tarsicio Castañeda, "The Chilean Health System: Organization, Operation and Financing," in *Health Economics: Latin American Perspectives* (Washington: Pan American Health Organization, 1989), pp. 3–25.

noncommunist countries, none has made more progress toward free markets than Chile. Yet Chile's progress in privatizing health care has been painfully slow. The only country that made substantial progress toward privatization of health care in the 1980s was Singapore. And significantly, Singapore is the only country in the world that has made a genuine commitment to individual self-insurance, rather than third-party insurance for medical expenses.

Methods of Privatization

In the 1990s, most countries with government-run health care systems are searching desperately for ways to reform them; and many politicians and health economists in other developed countries are exploring partial privatization and managed competition techniques. Not surprisingly, they often look to the United States for guidance. The irony is that, as they turn to the United States for market-based health care reforms, those Americans wedded to the bureaucratic vision of health care in this country are searching the globe to find a socialist health care system they can copy. The following briefly summarizes five methods of privatization in use around the world.

Method I: Free-Market Provision in the Face of Limited Free Services Provided by Government

The most common form of privatization is not the deliberate transfer of resources from the public to the private sector. Rather, it is the growth of private supply in the face of limited government supply. When free, government-provided health care is limited in availability or poor in quality, people naturally turn to the private sector. That is especially true among less-developed countries.

Private Provision in Less-Developed Countries[9]

Private health services still play a major role in all less-developed countries. The bulk of the people in Sub-Saharan Africa prefer the traditional, indigenous systems, and they use modern facilities only as a last resort. Private provision, both traditional and modern, also is important in Asia, North Africa, and Latin America. Hank Merrill, reporting on the use of health services by the Thais (a relatively

[9]This section is based on Gabriel Roth, *Private Provision of Public Services in LDCs* (Washington: World Bank, 1987).

sophisticated and advanced people), estimated that "only 15 percent of the persons requiring or seeking medical care in Thailand go to government-sponsored facilities. An additional 20 percent seek services from pharmacists and druggists, and 15 percent seek out traditional healers, spiritual advisors or injectionists."[10]

As Table 19.1 shows, private health expenditures in less-developed countries are often more important than in the industrialized countries. Particularly striking are the figures from Asia. In India, 84 percent of health care expenditures are private; in South Korea, 87 percent are private; and in the Philippines, 75 percent are private. These high percentages reflect not only the use of traditional medicine but also the increasing availability of private, modern health facilities.

The Growth of the Private Sector in Britain and New Zealand

In both Britain and New Zealand, hospital services are completely paid for by government. Yet, both countries have long waiting lists for hospital surgery (see chapter 17). In response to rationing by waiting, both countries also have a growing market in private health insurance—used by citizens who prefer to pay for prompt private surgery, rather than wait for free surgery in public hospitals. In Britain, the number of people with private insurance has more than doubled in the last 10 years, to about 12 percent of the population. Apart from private insurance, Britons make out-of-pocket payments to obtain benefits not available from the NHS, including immediate access to a hospital for nonemergency surgery. In New Zealand, one-third of the population has private health insurance, and private hospitals now perform 25 percent of all surgical procedures.

Private Alternatives in Canada

In Canada, too, health care is theoretically provided to all, with no user fees, coinsurance payments, or extra charges. Only three of the ten provinces have premiums. The government refuses to allow private health insurance to be sold, except for incidental items not covered by the provincial plans. Unlike the British and New Zealanders, Canadians generally cannot purchase private health insurance or make out-of-pocket payments to physicians. Private

[10]Ibid.

Table 19.1

PRIVATE EXPENDITURES AS A PERCENT OF TOTAL HEALTH EXPENDITURES IN LESS-DEVELOPED COUNTRIES

Country	Percent
Afghanistan (1975–76)	88%
Argentina[1]	69
Bangladesh (1976)	87
Botswana (1978)	48
Brazil (1981)	33+
China (1981)	32
Colombia (1978)	33
Ghana (1970)	73
Haiti (1980)	65
Honduras (1970)	63
India (1970)	84
Indonesia (1982–83)	62
Jamaica (1981)	40
Jordan (1982)	41
Lebanon (1982)	50+
Lesotho (1979–80)	12
Malawi (1980–81)	23
Mali (1981)	54
Mexico (1976)	31
Pakistan (1982)	71
Philippines (1970)	75
Peru (1982)	53
Rwanda (1977)	37
Senegal (1981)	39
South Korea (1975)	87
Spain (1976)	39
Sri Lanka (1982)	45
Sudan (1970)	41
Swaziland[1]	50
Syria[1]	76
Upper Volta (1982)	19
Tanzania[1]	23
Thailand (1979)	70
Togo (1979)	31
Tunisia[1]	27
Upper Volta (1981)	24
Venezuela (1976)	58
Zambia (1981)	50
Zimbabwe (1980–81)	21

SOURCE: David de Ferranti, "Paying for Health Services in Developing Countries: An Overview," World Bank Working Paper 721 (Washington, 1985); reprinted in Gabriel Roth, *Private Provision of Public Services in LDCs* (Washington: World Bank, 1987).

[1]No date.

pay for medical or hospital care is technically not prohibited. What is prohibited is for physicians or hospitals to treat both patients whose care is financed by the provincial plans and patients who pay directly. The Canadian physician or hospital practicing private medicine must be private only, and the number of private-only doctors and hospitals is very small.

The other private option for Canadians is the health care system of the United States. Four out of five Canadians live within 200 miles of the border, thus making U.S. health care relatively accessible. Increasingly, Canadians who are not willing to suffer long delays for major operations are taking advantage of this option.

Method 2: Privatization of Supply

In many countries the supply of health care services is completely socialized. The result is almost always inefficiency and higher costs. To deal with these problems some countries are contracting with the private sector to provide services. In others, private providers are allowed to compete with public providers on a reasonably level playing field.

Public-Sector Contracting with the Private Sector

In some countries, government health authorities contract with private hospitals to provide services. In Britain, more than 40 percent of government health authorities have some contracting arrangement in place. Clinical facilities such as pathology laboratories are the most frequent recipient of these contracts. Furthermore, about one-third of health authorities contract out long-term care to the private sector. These arrangements are generally long established with religious or charitable institutions.

Contracting with private facilities is also becoming more frequent in Canada. In this case, however, the private contractors are in the United States. For example, British Columbia's hospital administrators are now contracting with hospitals in Seattle to perform heart surgery, and Ontario's administrators are doing the same with hospitals in Detroit (see chapter 17). In both cases, Canadian hospital personnel apparently believe the U.S. hospitals can perform the surgery for a lower cost or can reduce the politically embarrassing waiting times. If it were not for the proximity of the United States, many Canadians might suffer and die because of their inadequate health care system.

Competition between Public and Private Suppliers

In many countries, private suppliers compete with public suppliers for patients, even though the bill is paid by government. In the United States, Medicare (elderly) patients and Medicaid (poor) patients can choose almost any public or private hospital, even though government is the health insurer. Private clinics also compete with public clinics in France and other European countries.

Method 3: Privatization of Demand—Health Insurance

In many parts of the world individuals cannot be effective consumers of health services because the government takes their income for earmarked health programs. Under these programs, people often have very little choice. As an alternative, some countries are finding innovative ways of empowering health care consumers by privatizing the demand for health insurance.

Private Health Insurance Alternatives in Chile[11]

Chile was the first nation in the Western Hemisphere to adopt a social security system, in 1924. It also is the first nation in the world to dismantle a public social security system through sweeping privatization. In 1981, the Chilean government created a new system under which workers contribute to private pension funds instead of the public system. Under the reform, workers who had participated in the old system were allowed to switch to the private system prior to 1986. All new entrants into the labor market are required to participate in the private system.

Today, about 90 percent of all Chilean workers are in the private-sector pension system. They are required to contribute 10 percent of their earnings to the Chilean equivalent of an individual retirement account. About a dozen companies compete to manage the accounts, and workers can switch back and forth among the investment funds. The fund managers are required to follow conservative investment strategies, and the Chilean government guarantees a minimum rate of return to all workers, as well as a minimum pension benefit at the age of retirement.

Workers under the new system are required to contribute another 3.5 percent of wages for the purchase of private life and disability

[11]See Goodman and Ferrara.

insurance from the approved private insurance companies of their choice. These private insurance policies replace the survivors and disability benefits paid by the old system for preretirement disability or death. The disability policy, along with funds accumulated in the worker's retirement account, pays a monthly benefit for the rest of the worker's life equal to 70 percent of the average wage earned during the 12 months prior to disability. The life insurance policy, along with the worker's retirement fund, pays a benefit to a surviving spouse, dependent parents, or dependent children. The disability benefits under the new system amount to more than twice those under the old system, and the new system's survivors benefits are almost double. In addition, the government guarantees the same minimum benefit for disability as for retirement and guarantees minimum survivors benefits as well.

Rates of contribution for Chilean workers are shown in Table 19.2 for 1985—the last year in which workers could exercise choice. As the table shows, those who opted out of the public-sector social security system were required to contribute 13.5 percent of their income (10 percent for retirement savings and 3.5 percent for disability and life insurance) to private funds. Had they remained in Chile's social security system, they would have paid about 19–20 percent of their income in social security taxes. Thus, the choice to opt out is worth savings equal to about 6 percent of earnings each year.

Workers under the new system also are required to contribute about 6 percent of wages for health insurance coverage, and they can choose between private health insurance companies and the government health service. Private health insurance policies must provide benefits at least as good as those promised by the government's health insurance. Although this option has been in place for more than a decade and despite Chile's success in privatizing retirement pensions, only 25 to 35 percent of Chilean workers have opted for private health insurance. There are apparently three reasons for the low rate of privatization. First, although the government widely publicized the private alternative to social security, it publicized the private health insurance option very little. Even today, most Chilean workers probably do not realize they can opt out of government health insurance. Second, as Table 19.2 shows, the government created little or no financial incentive for choosing

Table 19.2
FINANCIAL INCENTIVES TO OPT OUT OF CHILEAN SOCIAL SECURITY, 1985

	Tax Rate
Total payroll tax rates for workers who opt in[1]	
Old-age, survivors, and disability insurance	18.89% – 19.94%
Health insurance	5.75% – 6.55%
Total payroll tax	24.64% – 26.49%
Required contribution for workers who opt out	
Retirement account	10.0%
Health insurance	6.0
Disability and life insurance	3.5
Total contribution rate	19.5%
Financial incentive to opt out[1]	5.13% – 6.99%

SOURCES: *Social Security Programs throughout the World 1985*, p. 52; and John C. Goodman and Peter A. Ferrara, *Private Alternatives to Social Security in Other Countries*, NCPA Policy Report no. 132 (Dallas: National Center for Policy Analysis, April 1987).

[1]The first rate given is the rate paid by workers participating in the general system for manual workers; the second rate is for workers participating in the general system for salaried workers.

private health insurance. Third, privatizing health insurance clearly has not been a high priority for the government.

If Chile continues to privatize social insurance, it will have to turn its attention to health care. More thought must be given to the mechanics of privatization. Private insurers should have no difficulty improving upon the benefits offered by the state for 6 percent of the income of workers who are young, healthy, and earn high wages. They may find it impossible to do so for workers who are old, less healthy, and/or low paid. Unlike pension benefits, use of health care services does not rise in proportion to income, and the current option could lead to large problems of adverse selection. In addition, to encourage private health insurance, the government must also encourage private health care delivery.

Even so, Chile has already made a major contribution to the privatization revolution. Chile's is the only government that has almost completely privatized social security, an accomplishment that may now be copied by other less-developed countries, including Colombia.[12] And Chile's is the first government in the world to create a private-sector alternative to participation in national health insurance.

Public Contracting for Private Health Insurance in the United States

In the United States, the contracting out of health care services is still in the infant stage. Currently, nearly 2 million Medicare (elderly) beneficiaries and 2.5 million Medicaid (poor) beneficiaries are enrolled in private prepaid health plans. These include Medicare beneficiaries who have exercised the option to enroll in a health maintenance organization (HMO) or a competitive medical plan (CMP).[13] Medicare pays the HMO or CMP a monthly lump sum equal to approximately 95 percent of Medicare's costs for the average beneficiary, adjusted for certain characteristics such as age, sex, county of residence, and whether or not the beneficiary is eligible for Medicaid or is institutionalized. Approximately 158 HMOs or CMPs in 34 states now have Medicare beneficiaries. The advantages of this alternative are significant. First, the private health option

[12]See "Privatizing Social Security," *Executive Alert* 5, no. 1 (January/February 1991): 6.

[13]CMPs are HMOs that do not have an official designation of "health maintenance organization." However, they are HMOs for all practical purposes.

increases choice in health care. Of the 33.7 million Medicare beneficiaries in the United States, about 10.5 million, or one-third, live in areas where at least two competing private plans are available in addition to traditional Medicare. Many HMOs and CMPs offer greater benefits than those provided under Medicare. Seventy-six percent of the plans, for instance, offer greater hospital coverage. Deductibles and copayments are often smaller and, in some cases, nil. Joining a private plan also reduces paperwork for the elderly, since their claims are handled by the private plan.

Another very new innovation is Medicare insured groups (MIGs). These groups are for elderly retirees who are covered by employer or union postretirement plans designed to supplement Medicare coverage. The MIGs permit employers to combine their Medicare and private benefits in one package, to integrate cost management. Retirees benefit because a MIG handles their paperwork and permits them to stay in the same plan they used during their working years. Among the private companies that have participated or are about to are Chrysler Corporation, Southern California Edison, John Deere Company, and Amalgamated Life Insurance Company.[14]

Method 4: Privatization of Demand—Private Savings as an Alternative to Health Insurance

A popular alternative to social insurance schemes is the provident fund. A provident fund involves forced savings: individuals (and/or their employers) are required to contribute to savings accounts, and the funds are reserved for contingencies such as illness and retirement. Although governments often influence such funds, the managing boards of the funds typically are composed of representatives of management and labor.[15] Individuals have a property right to their share of the fund. At least 21 countries have mandated

[14]Both Chrysler and Southern California Edison have completed demonstration projects, but have decided not to implement the program. Source: Health Care Financing Administration (HCFA), Office of Research and Demonstration, Comprehensive Health Services Branch (Baltimore).

[15]In all cases, the workers bear the full economic burden of the programs. Some programs are designed so that the burden appears to be on the employer, or appears to be shared between the employee and employer. Over time, however, the forces of supply and demand lead to reductions in real wages that redistribute the burden, causing it ultimately to be on the employee.

participation in such plans for certain classes of workers—usually employees of large firms in urban areas.[16]

The Use of Provident Funds for Health Care Expenditures

Although the primary purpose of provident funds is to provide savings for retirement (or survivors benefits), many of these funds also permit withdrawals for other purposes, such as health care. For example:[17]

- Almost all provident funds permit their members to withdraw their share of the fund in the case of permanent disability.
- In Ghana and Montserrat, limited withdrawals are permitted in the case of sickness.
- In Kenya and Singapore, withdrawals are permitted to pay for hospitalization expenses.
- In India, withdrawals are allowed to pay for medical expenses.
- In Nepal, provident fund members are entitled to borrow from their accumulated deposits for medical expenses.
- In Zambia, withdrawals are permitted for maternity expenses.

Medisave Accounts in Singapore[18]

In 1955, Singapore introduced a compulsory savings program that now covers about three-fourths of all Singaporean workers.[19] Employer and employee contributions are made to the Central Provident Fund (CPF), which is controlled by the government and has a monopoly status. In the beginning, the CPF invested its funds entirely in government securities, and withdrawals were essentially limited to lump sum retirement benefits or survivors benefits. Over the years, the program has acquired flexibility. Workers can now direct the investment of up to 40 percent of their CPF funds[20] and

[16]See Goodman and Ferrara.

[17]Ibid.

[18]This discussion is based on Goodman and Ferrara; and Armina Tyabji, "Financing Social Security in Singapore," a presentation made to an Atlas Foundation conference, Arlington, Va., May 19, 1990. See also "The Report of the Central Provident Fund Study Group," *Singapore Economic Review* 31, no. 1 (April 1986).

[19]The program does not include people who are self-employed and people, such as university employees and pensionable civil servants, who are covered by separate plans.

[20]Investments may be made in real estate, in approved stock in Singaporean companies, and in gold. People are not allowed to purchase bonds or shares of stock in foreign countries.

can withdraw funds to purchase a home, buy life insurance, or buy home mortgage insurance; and they can borrow funds from their accounts to pay college education expenses for a family member.[21]

The required rates of contribution to CPF accounts over the past 36 years are shown in Table 19.3. Given that employer contributions on behalf of employees are undoubtedly made in lieu of the payment of wages, the table shows that the forced savings rates in Singapore have been quite high—totaling 50 percent of the first $41,000 of wages (in U.S. dollars) in 1985.[22] For the future, the government is committed to gradually moving toward a contribution rate of 40 percent—20 percent each for employees and their employers.

All employees in Singapore have a private property right to the funds that accumulate in their individual CPF accounts. The funds may be withdrawn at retirement, in the event of permanent disability, or if the individual emigrates from Singapore. At the account holder's death, the funds are payable to the individual's heirs.

Singapore's tax rates are high—probably much higher than rates that would be imposed were the United States to adopt a similar system. On the other hand, even Singapore's tax rates are low compared to the tax rates the United States will have to impose if it continues with its pay-as-you-go system of funding postretirement health care and retirement pensions (see chapter 13). Moreover, it is one thing to force individuals to sacrifice for their own and their family's future. It is another matter to force a current worker to sacrifice so that unrelated current retirees can live at a standard above that of the worker.

Prior to 1987, funds were withdrawn as a lump sum at retirement. Beginning in 1987, however, the government required retirees to use the first $18,600 (single) or $27,900 (couple) to purchase a monthly retirement annuity equal to $143 (single) or $214 (couple). Retirees can use the balance of their fund for any purpose. However, as Table 19.4 shows, the bulk of CPF withdrawals have been used to purchase a home, usually well before the time of retirement. About 86 percent of the housing in Singapore has been built by the

[21]These loans must be repaid.

[22]All figures expressed in U.S. dollars in this discussion are based on a conversion rate of $1.76 in Singaporean currency equals $1 in U.S. currency.

Table 19.3
FORCED SAVINGS IN SINGAPORE: FEATURES OF THE CENTRAL PROVIDENT FUND, 1955 TO 1991

	Required Contribution Rate					
Beginning	Employer	Employee	Total	Maximum Taxable Wage[1]	Size of Fund at End of Year (S$ Millions)[1]	Number of Members at End of Year (Thousands)
July 1955	5.0%	5.0%	10.0%	$6,000	$9	180
Sept 1968	6.5	6.5	13.0	27,692	540	505
Jan 1970	8.0	8.0	16.0	22,500	777	639
Jan 1971	10.0	10.0	20.0	18,000	988	715
July 1972	14.0	10.0	24.0	18,000	1,316	855
July 1973	15.0	11.0	26.0	18,000	1,771	962
July 1974	15.0	15.0	30.0	18,000	2,414	1,042
July 1975	15.0	15.0	30.0	24,000	3,235	1,104

July 1977	15.5	15.5	31.0	24,000	4,954	1,251
July 1978	16.5	16.5	33.0	36,000	5,981	1,341
July 1979	20.5	16.5	37.0	36,000	7,516	1,436
July 1980	20.5	18.0	38.5	36,000	9,551	1,519
July 1981	20.5	22.0	42.5	36,000	12,150	1,650
July 1982	22.0	23.0	45.0	36,000	15,656	1,725
July 1983	23.0	23.0	46.0	48,000	19,505	1,779
July 1984	25.0	25.0	50.0	60,000	22,670	1,847
July 1985	25.0	25.0	50.0	72,000	26,829	1,892
April 1986	10.0	25.0	35.0	72,000	29,341	1,932
July 1988	12.0	24.0	36.0	70,000	32,529	2,063
July 1989	15.0	23.0	38.0	72,000	36,052	2,126
July 1991	17.5	22.5	40.0	72,000	42,000	2,200

SOURCE: Central Provident Fund, *Annual Report* (various years).
[1]S$1.76 = U.S.$1.00.

government and of these units, 70 percent have been purchased by their occupants—with CPF money.

Beginning in 1984, the government of Singapore extended its program of forced savings to require that a certain portion of CPF contributions be put into "Medisave accounts" to provide funds for hospitalization. The funds may be used only for treatment at a government hospital or an approved private hospital.[23] Strangely, Medisave funds cannot be used to purchase outpatient care, including physicians' services or expensive outpatient renal dialysis and long-term care. People also cannot borrow against future Medisave deposits to pay current bills at private hospitals, although members of the same family can pool their Medisave balances to pay another family member's hospital bill, and people who enter some government hospitals can settle their bills from future Medisave deposits.

Currently, 6 percent of an employee's salary is placed in a Medisave account until the balance reaches approximately $8,522. Once that total is reached and maintained, any additional contributions are automatically placed in an individual's ordinary pension account. In Singapore, $8,522 would be sufficient to cover hospitalization expenses except in very rare catastrophic cases. The Singapore government currently is engaged in negotiations with private health insurance companies and is apparently committed to allowing some portion of the Medisave account funds to be used for the purchase of health insurance coverage. In 1985, 145,000 members of the CPF (out of a total Singapore population of 2.6 million) made Medisave withdrawals averaging about $171 per person. As Table 19.4 shows, the use of Medisave funds quadrupled between 1985 and 1988.

A Medisave account is self-insurance for hospitalization throughout the employee's working life. At retirement, individuals must leave about $4,830 in their Medisave account to cover medical expenses after they reach the age of 55.[24] Singapore's Medisave program, therefore, combines the concepts of the Medical IRA (MIRA) and the Medical Savings Account discussed in this book.

[23]Hospital patients also face copayments, which they must make with out-of-pocket funds, in addition to payments from Medisave accounts.

[24]When Medisave accounts were started in 1984, the required balance was S$5,000 or the actual balance, whichever was lower. Subsequently, that amount has increased by S$500 per year, and it will continue to increase until it reaches S$10,000 in 1994.

Table 19.4
WITHDRAWALS FROM FORCED SAVINGS ACCOUNTS, BY USE, 1968 TO 1989
(S$ MILLIONS)[1]

Year	Total	Approved Housing Schemes	Reached 55 Years of Age[2]	Leaving Singapore Permanently	Medisave	Death	Other[3]
1968	$30.7	$6.3	$14.9	$5.0		$1.8	$2.7
1969	42.4	21.7	13.3	4.2		2.0	1.1
1970	45.7	22.9	15.4	4.2		2.0	1.1
1971	56.4	23.2	22.1	7.0		3.2	0.9
1972	57.9	25.1	23.8	4.1		3.8	1.2
1973	93.5	50.6	31.4	5.7		4.7	1.0
1974	154.3	92.8	46.4	8.1		5.5	1.6
1975	216.9	134.8	60.9	11.2		8.4	1.5
1976	377.7	275.2	76.2	14.1		9.3	2.9
1977	503.5	383.5	90.0	14.1		12.6	3.4
1978	657.8	488.4	123.1	15.7		13.8	16.8
1979	629.3	438.6	150.7	18.2		15.1	6.7
1980	779.1	520.9	213.9	23.2		15.6	5.4
1981	1,967.6	691.1	294.5	33.0		19.5	29.5
1982	1,241.2	796.3	322.9	56.4		27.1	38.5

(Continued on next page)

Table 19.4—Continued
WITHDRAWALS FROM FORCED SAVINGS ACCOUNTS, BY USE, 1968 TO 1989
(S$ MILLIONS)[1]

Year	Total	Approved Housing Schemes	Reached 55 Years of Age[2]	Leaving Singapore Permanently	Medisave	Death	Other[3]
1983	1,717.9	1,122.4	437.8	104.3		31.3	22.1
1984	3,509.3	2,692.9	606.0	96.4	$17.6	35.6	60.8
1985	3,359.7	2,566.4	506.2	146.3	43.9	40.5	56.4
1986	3,823.8	2,647.3	666.3	156.8	104.8	44.4	204.2
1987	4,297.2	2,647.5	548.0	143.9	140.5	48.6	168.7
1988	4,010.2	2,776.1	573.5	151.7	169.9	52.2	286.8
1989	3,663.3	2,415.1	619.4	161.5	178.2	54.2	234.9

SOURCES: *Economic and Social Statistics of Singapore 1960–1982* (Department of Statistics, 1988); *Singapore Yearbook of Statistics 1988;* and Central Provident Fund, *Annual Report, 1989.*

[1]S$1.76 = U.S.$1.00.

[2]Retirement age.

[3]Includes withdrawals for physicial and mental disability, for purchase of home mortgage insurance, and for investments in nonresidential real estate and approved shares of stock and gold.

Like most other provident fund systems around the world, the Singapore system forces people to save but allows them to make withdrawals for many of the purposes for which people ordinarily engage in private, voluntary savings—retirement, disability, death, education, medical expenses, and the purchase of a home. Singapore's provident fund differs from others in that there is very little insurance (and therefore no pooling of risks) for adverse contingencies such as hospitalization, disability, or death. What individuals receive in the event of these contingencies is based solely on their own contributions. An exception is compulsory mortgage insurance, for which the premium is paid from the buyer's CPF account.

The Singaporean system is far from perfect. Restrictions on the use of Medisave funds encourage people to overuse hospital care and underuse less expensive alternatives. Certain restrictions favor public over private hospitals (although Singapore now is privatizing its public hospitals) and discourage the development of a competitive market for hospital care. And some restrictions against borrowing from future Medisave deposits to pay current expenses seem unwise, since medical expenses cannot be timed to match the buildup of Medisave funds.

On the other hand, Singapore already has developed one of the most innovative ways of paying for health care found anywhere in the world—a vast system of individual self-insurance. The government of Singapore expects each individual to pay his or her own way and forces people to save for needs met by governments in most other countries. The program has been highly successful. Table 19.5 is an indication of how much progress has been made. As the table shows, the Singapore welfare state has steadily shrunk over the past two decades and is now largely devoted to helping the low-income elderly, who participated in the program for only a few years. As Table 19.6 shows, only among older workers are there many who have failed to accumulate substantial savings. On the other hand, young and middle-aged people are doing well. For example, in the 45–49 age group, 70 percent have savings of more than $17,000 (S$30,000).

Method 5: Market-Based Reforms As a Precondition for Privatization

Although some countries have introduced market-based reforms into government-run health care systems, it is clear that in Britain

Table 19.5
PUBLIC ASSISTANCE IN SINGAPORE, 1970 TO 1987

Year	Total Number of Cases Paid	Percent Elderly	Total Expenditures[1]
1970	10,982	57.6%	$3,517
1971	8,915	61.3	2,720
1972	7,881	62.6	2,341
1973	7,407	63.2	3,042
1974	7,031	63.1	2,917
1975	7,015	61.4	2,936
1976	6,640	63.9	3,618
1977	6,375	67.0	3,534
1978	6,330	67.1	3,518
1979	5,994	66.7	3,311
1980	4,580	69.2	3,165
1981	3,505	73.7	2,582
1982	3,297	75.6	3,066
1983	3,241	86.0	3,249
1984	3,278	88.7	3,600
1985	3,126	88.7	3,544
1986	3,004	NA	3,513
1987	3,082	NA	3,416

SOURCE: Ministry of Social Affairs, *Annual Report* (various years).
[1]In Singaporean dollars; S$1.76 = U.S.$1.00.

Table 19.6
CPF BALANCES OF ACTIVE MEMBERS, 1988

Age Group	Percentage of Age Group with Balances Below		
	S$30,000[1]	S$20,000[1]	S$10,000[1]
45–49	29.1%	21.6%	13.0%
50–54	27.0	19.5	10.9
55–59	58.4	41.4	24.5
60 and above	85.6	74.4	53.7

SOURCE: Computed from Central Provident Fund, *Annual Report 1989*.
[1]S$1.76 = U.S.$1.00.

and New Zealand the authors of the reforms have intended them as precursors to more far-reaching goals.

Case Study: Britain[25]

Under Margaret Thatcher, Britain became the leader of the international privatization revolution in the 1980s. Although the Thatcher government never formally proposed privatization of the NHS, a major step in that direction was taken with the health care reforms proposed in 1989 and implemented in 1991. As outlined in *Working for Patients*,[26] the government proposed to introduce competition and market incentives into the health care sector.

The single most important change is the separation of the purchase from the provision of health care. Under the new system, district health authorities (DHAs) have the responsibility to purchase health care for the residents of their districts. But they need not purchase hospital care from hospitals in their own areas. Nor are they confined to NHS hospitals. They may shop in a national hospital marketplace and purchase public or private hospital care. To encourage competition in the hospital sector, NHS hospitals are allowed (and even encouraged) to form hospital trusts—self-governing entities that can raise capital, negotiate employment contracts, and function as self-contained business entities. It is important to note that only DHAs, not patients themselves, make choices among hospitals.

In the primary care sector, a new system of paying physicians is designed to encourage competition among general practitioners (GPs) for patients, a feature that had largely been absent from the British health care system. In addition, in a move to encourage payment for performance, GPs will receive bonus payments for meeting targets for services such as vaccinating, immunizing, and screening. GPs also are allowed to become budget holders, with each establishing a sort of miniature HMO, which purchases diagnostic services and hospital services for patients. Under the system, GP budget holders have incentives to purchase lower cost hospital services and even to perform elective surgery themselves if the price of hospital surgery is too high. As of the fall of 1991, about 10

[25]See Day and Klein; and Enthoven.

[26]Secretary of State for Health, *Working for Patients* (London: Her Majesty's Stationery Office, 1989).

percent of GP practices had become budget holders, a number that was expected to double by April 1992.[27] Of 1700 NHS hospitals in existence in the fall of 1991, 56 had become self-governing, a number that was expected to triple by April 1992.[28]

The future of these reforms is uncertain, in that they have been vigorously opposed by the British Medical Association, as well as by the Labour party. Nonetheless, an important tactic of the Conservative party in all areas of the economy is that of initiating reforms that generate their own special-interest defenders over time.[29] The tactic may work in health care as it has elsewhere.

Case Study: New Zealand

In the 1980s, New Zealand underwent more economic liberalization than any other country in the world, virtually eliminating agricultural subsidies and steadily phasing out tariffs and quotas. Financial markets were totally deregulated, and almost any foreigner can now start a bank there. The country not only deregulated commercial airline travel, but it even began allowing Australian carriers to freely compete in its domestic market. It was only natural that New Zealand should launch a major program of health care reform.

In 1991, the New Zealand government announced a plan that combines several of the methods of privatization listed above—Chile's method of allowing individuals to opt out of public insurance and obtain private insurance, the U.S. method of allowing public-private competition in the supply of services, and the British plan to introduce market-based reforms into the public sector. The New Zealand plan features four major changes. First, all of New Zealand's public hospitals will be "corporatized." That means they will be turned into business entities with profit and loss statements, a common precursor of privatization in many countries. Second, public hospitals will be forced to compete with private hospitals for patients on a level playing field. Third, four regional health authorities will be created to negotiate contracts with providers, who will be forced to compete for business. Finally, individuals will

[27]Day and Klein, p. 54.

[28]Ibid., p. 52.

[29]See Madsen Pirie, *Dismantling the State: The Theory and Practice of Privatization* (Dallas: National Center for Policy Analysis, 1985).

be able to choose private insurance over participation in public insurance and will receive a tax rebate or a voucher in compensation.[30]

At the time of this writing, the final details of New Zealand's reforms are unknown. However, the government's commitment to the principles described above ensures that New Zealand's health care reform will be one of the most significant international health policy developments in the 1990s.

Options for Reform

A rich, multinational menu of health care privatization techniques exists today. Resistance to these techniques is inevitable. But as events in Singapore, Chile, Britain, New Zealand, and—to a lesser extent—in the United States show, privatization in health care is possible.

[30]One of the authors served as a consultant to a task force (chaired by Alan Gibbs) that made the initial proposals in the late 1980s. The proposals were further refined in Patricia Danzon and Susan Begg, *Options for Health Care in New Zealand: Options for Reform* (Wellington: New Zealand Business Roundtable, 1991).

20. Meeting the Needs of Underserved Populations

A widespread belief in the health policy community is that special groups of people are being underserved by the U.S. health care system. They include (1) low-income families, (2) uninsured people, and (3) people who live in rural areas.[1]

In view of the amount of political rhetoric focused on the problems of these three groups, it is surprising how little is actually known about their "unmet health care needs." Most of the available information is anecdotal, and many of the conclusions reached are based on indirect inferences (such as inferences drawn from the availability of physicians and hospitals) rather than on factual studies of actual needs (see chapter 10).

To our knowledge, no scholarly study has ever attempted to relate unmet health care needs to the institutional structures of the health care system. For example, specialists believe that about half the diabetics in the United States have not been diagnosed and treated by a physician (see chapter 17), but no one has attempted to demonstrate that a structural change in our health care system (for example, expansion of Medicaid, or employer mandates) would lead to more diagnosis and treatment. Half the diabetics in Britain are also undiagnosed and untreated, even though health care in Britain is theoretically free to all at the point of delivery.

This chapter proposes solutions to the problems of the underserved populations. It differs from almost all other commentaries in three ways. First, almost all other proposals designed to meet the needs of underserved populations begin with assertions about

[1]These categories are not mutually exclusive; all three characterizations could be used to describe the same family.

the nature of the needs and end with unproved assertions about how a policy change will result in more needs being met. By contrast, the solutions proposed here begin with the recognition that very little is known about how changes in health care institutions will affect those needs. Our argument for reform is quite different: The structure of the existing system arbitrarily and unfairly discriminates against certain population groups, and reform is justified on those grounds alone.

Second, almost all other policy proposals designed to meet the needs of underserved populations call for more government spending. Yet there is no known evidence that the United States is spending too little money on health care. Instead, the proposals presented below are designed to redirect the amount of money that is currently being spent to give individuals and communities greater freedom to control their own health care dollars and make their own decisions.

Third, almost all other policy proposals call (either directly or indirectly) for more government regulation and control of the medical marketplace. By contrast, the proposals made here call for government to retreat, thereby empowering individuals and communities and encouraging the development of market-based institutions.

Ten Policy Proposals

What follows is a discussion of ten proposals to meet the needs of underserved populations in ways that do not require more government spending and control. These proposals are briefly sketched, to give policymakers a general idea of concepts that need to be more fully developed. The rest of the chapter provides much greater detail on two of them—the concept of medical enterprise zones and the concept of a workable pay-or-play plan that guarantees universal health insurance.

1. Medical Enterprise Zones

In certain areas of the country, especially rural areas, the number of doctors and hospital beds per capita is well below the average for the country as a whole. These areas are often called underserved areas. The people who live in them are not necessarily deprived of medical care. They can travel to a neighboring area that is not underserved. But the cost and inconvenience of travel may create special burdens for many, especially low-income patients.

One of the reasons why underserved areas are underserved is that many of the laws and regulations written in Washington and in state capitals unreasonably restrict options and opportunities for rural residents. For example, regulations that may make sense for middle-income patients in large cities often make no sense for low-income families in rural areas. Medical Enterprise Zones (MEZs) are designed to solve this problem. Within specially designated areas, many of the regulations would be suspended, creating new options and opportunities for people to meet their own needs with limited resources. For example, within an MEZ, hospitals would not be required to employ a full-time dietitian or maintain 24-hour-a-day services of a registered nurse. Ordinary homes would be allowed as places in which long-term care could be delivered. And nurses, physicians' assistants, and paramedics would be allowed to deliver certain types of primary care. (See the expanded discussion below.)

2. Medical Enterprise Programs

The central idea behind the Medical Enterprise Zones is that there are distinct geographical areas within which people do not now have access to medical providers and facilities because the providers and facilities are not there. The problems faced by the urban poor are different. Providers and facilities may be nearby, but families have been priced out of the market by regulations not designed to meet their needs. Many of the regulations that govern the medical marketplace meet middle-class needs and desires. The urban poor, with less money to spend, are not given the option to choose less expensive alternatives.

Closely related to the concept of the MEZ is the concept of the Medical Enterprise Program (MEP). Unlike MEZs, MEPs are not defined by geography. Instead they are defined by the market that providers are serving. Thus, doctors, nurses, physicians' assistants, and other providers could be designated as Medical Enterprise Program providers, and hospitals, nursing homes, and other facilities could become MEP facilities if they were primarily providing services for low-income families. Under an MEP, providers and facilities would be as free of cost-increasing regulatory burdens as they would be if they operated in an MEZ. Moreover, because MEP status is defined in terms of markets being served, it is possible to

conceive of a physician serving as an MEP provider while working at a clinic in a low-income neighborhood, although the same physician would be subject to normal regulations while practicing at a different location in another neighborhood.

3. Decentralized Medicaid

One of the biggest problems with the Medicaid program is that the decisionmakers who write the rules and regulations are often far removed from the problems they are attempting to solve. Politicians (pressured by special-interest groups) decide who is eligible and who is not, and in many ways dictate how health care is to be delivered. Often, their decisions result in an enormous waste of resources and prevent local communities from solving problems in a reasonable way. The regulations governing nursing homes are one of the most obvious examples.

Almost all people involved in rural health care can point to numerous ways in which health care dollars could be better spent, were it not for federal and state regulations. It's time to give them the opportunity. Medicaid funds should be turned over to local communities with only one restriction: The funds must be spent on indigent health care. The people who actually have to solve problems at the local level should be given the freedom to make decisions about who will be eligible for assistance and what type of health care is appropriate.

4. Community-Centered Welfare

As shown repeatedly in this book, decisions about health are related to many other decisions in life. Given limited resources, it is not obvious how much money should be spent on physicians and hospitals rather than on housing, food, and other goods and services. Currently, those decisions are made by politicians who govern what we loosely call the welfare state. Better decisions are likely to be made by people in local communities faced with real problems.

Accordingly, we propose that all means-tested welfare spending be turned over to local communities with only one restriction: The funds must be spent to help low-income people. Under Community-Centered Welfare (CCW), the amount given by federal and state governments would not be determined by arbitrary eligibility standards devised in the political process. Instead, the amount of CCW

funds each community receives would be solely a function of the amount and degree of poverty in that community.

5. Privatized Community-Centered Welfare

Numerous studies have shown that private-sector charities outperform government welfare programs. For example, in most communities, the Salvation Army does a much better job of meeting real needs than the Aid to Families with Dependent Children (AFDC) program does. Ordinary people agree with the scholars. Although billions of dollars are given to private charity each year, there are very few private gifts made to the AFDC, food stamp, or Medicaid programs.

Given the demonstrated superiority of the private sector, a strong case exists for privatizing CCW. One way to accomplish that would be to have communities specify their objectives and have private agencies compete for CCW funds. The winners would operate under contract for a limited period of time, after which the bidding process would be renewed. Note that the concept of privatized CCW advocated here is very different from the block grant program, popular in the 1970s. When the federal government made block grants, the recipient organizations began to lose their originality and adopt the federal government's view of poverty.[2] A genuinely privatized CCW program would reflect local community values, not the values of federal politicians.

Allowing local governments to award contracts to private-sector agencies still leaves room for politicians and special-interest groups to distort the purposes of the program. Thus, if there were a way to bypass politicians altogether, the results would be much better. Fortunately, a detailed proposal to achieve that end has been developed.[3]

Currently, the amount of means-tested federal welfare spending is equal to about one-third of personal income taxes. Accordingly, we should allow each individual taxpayer to allocate up to one-third of his or her tax liability to any qualified private-sector organization meeting legitimate welfare needs. Under this proposal, all private and public welfare programs would compete on a level playing field

[2]See John C. Goodman and Michael D. Stroup, *Privatizing the Welfare State,* NCPA Policy Report no. 123 (Dallas: National Center for Policy Analysis, June 1986).

[3]Ibid.

for taxpayer funds, and the taxpayers themselves would make the ultimate decisions about where the money goes.

6. A Play-or-Pay Plan That Works

In chapter 10, we discussed the harmful effects of employer mandates and play-or-pay proposals advanced at the state and national level. If our own proposals were adopted, however, a different kind of play-or-pay system would emerge—one which has most of the advantages and very few of the disadvantages of other plans.

The most common complaint about the existence of a large population of uninsured people is that they get a free ride, paid for by the rest of us. Since uninsured people usually get treatment if they are sick (at least in the case of medical emergencies), when they don't pay their medical bills, they get care subsidized by everyone else through the tax system or through cost shifting. But is this complaint really valid? Note that people who are uninsured are people who are not taking advantage of the generous tax subsidy for employer-provided insurance. As a result, other things being equal, the uninsured pay higher taxes than people with employer-based insurance. In fact, a back-of-the-envelope calculation suggests that the uninsured pay about $6 billion or $7 billion more in taxes each year because they do not get the average tax subsidy enjoyed by other taxpayers. Because the amount of annual unpaid hospital bills generated by the uninsured is also about $6 billion or $7 billion, it is by no means clear that the uninsured get more in free health care than they pay in additional taxes.

The difficulty with the existing system is not that the uninsured are getting a free ride at everyone else's expense. Instead, there are two other problems. First, the tax subsidy for health insurance is arbitrary and unfair. It is a regressive system under which most of the benefits go to higher income families, and it arbitrarily excludes people who purchase health insurance on their own. Second, under the current system, most of the additional taxes paid by the uninsured go to Washington rather than to local hospitals that provide the free care.

A remedy for the first problem (as discussed repeatedly in this book) would be for everyone to receive a tax subsidy for the purchase of health insurance. And the lower a family's income, the

higher the subsidy should be. At the bottom end of the income scale, there should be refundable tax credits, with government directly paying a portion of the health insurance premium. A remedy for the second problem is to redirect the additional taxes paid by the uninsured to local hospitals that administer free care. Thus, individuals who choose not to be insured would pay more in taxes, and those additional taxes would help fund uncompensated care delivered to the uninsured.

Under this proposal, no one would be required to purchase health insurance. Those who chose not to would be forced to rely on charity care if they could not pay their own medical bills. Existing laws generally require hospitals to provide emergency care to patients, regardless of ability to pay. With the new source of funds proposed here, we could liberalize access to health care for indigent patients. But free care is unlikely to be perceived as being as desirable as purchased care, and it may involve health care rationing. Thus, people will have incentives to purchase health insurance—first, to protect their own assets; second, to acquire the quality of health care they want; and third, to be able to exercise choice in the medical marketplace.

7. Medical Spending Accounts

The concept of medical spending accounts is not new. Many middle-income employees of large companies use such accounts to pay expenses not covered by conventional health insurance (as noted elsewhere in this book). What is proposed here is to extend the option to low-income families as well.

Medical spending accounts are a way of empowering low-income patients and freeing them from the arbitrary shackles of the Medicaid and Medicare programs. A pregnant women on Medicaid, for example, should be given an opportunity to spend from such an account (with the right to add other funds and pay market prices) in the market for prenatal care (see chapters 3 and 4).

This concept can be expanded to other areas. For example, admission to a nursing home under government programs is supposed to be governed by specific physical disabilities. Rather than furnish nursing home care, however, we could establish a spending account—allowing patients the alternative of purchasing home care, drugs, and other services. The amount of the account might

vary, depending on the degree of the disability. At a minimum, patients should have options. And granting them options makes it likely that a great deal of money could be saved. For example, it seems likely that many patients in nursing homes (at a cost of $25,000 per year) would be willing to seek alternatives in return for a $1,000-per-month medical spending account.

8. Medisave Accounts

A natural extension of the concept of medical spending accounts is the creation of full-fledged medical savings accounts. Enormous premium savings are possible for people who choose high, rather than low, deductibles under their private health insurance policies (see chapter 8). The same principle applies to public insurance, including Medicaid.

Accordingly, Medicaid patients should have the option of choosing high-deductible coverage and placing the premium savings in tax-free Medisave accounts. They should also be allowed to add other funds, up to the amount of the annual deductible, and they should be permitted to spend their Medisave funds freely in the medical marketplace—without regard to Medicaid's normal regulations and restrictions.

9. A Real Voucher Program

There have been many proposals to create health insurance vouchers for low-income people. Such proposals, however, will do little to create real empowerment unless insurers are free to offer significant diversity on the supply side. In most communities where parents have been allowed to choose among different branches of the same school system, the option to choose has proved to be of small value.

A voucher system that results in real empowerment is one that allows insurers wide discretion in the types of services they may offer. For example, providing institutions must be free to greatly reduce the amount they spend on care for premature babies in return for expanded prenatal care (or Medisave account money to purchase prenatal care). They must be free to greatly reduce the money spent on heroic medical services in return for more preventive services. They must be free to offer more home care, less institutionalized care, etc.

If insurance suppliers were allowed options, and Medicaid patients were given the right to exercise choice, low-income families would soon enjoy something they are now denied—the benefits of a competitive market.

10. Liability by Contract

Under traditional common-law doctrine, hospitals delivering charity care could not be sued for their torts. The theory was that because patients were receiving free care, there was no normal contract. Thus, they could not sue for negligence arising under the relationship. The doctrine of charitable immunity was eroded by a series of court decisions, and, for all practical purposes, it no longer exists today. In fact, many physicians regard Medicaid patients as the ones most likely to sue. As a result, some physicians engage in costly defensive medicine and others avoid Medicaid patients altogether.

One solution is to return to the older doctrine under which people who chose to receive free care would not be able to sue those who provide it. The disadvantage of that approach is that the tort liability system may be the only force maintaining quality under the current system in which government programs are putting relentless pressure on providers to cut costs. A different solution is possible, however, if Medicaid patients are allowed to become full participants in a competitive marketplace. Under this solution, patients would be allowed to exercise choices and negotiate liability arrangements on their own.

All patients should have the right to exercise freedom of contract in the realm of tort liability (see chapter 3). Thus, in return for patient life and disability insurance covering a medical episode, providers should be free to offer a lower price to patients who waive their right to sue for simple negligence. Because the hospitals would have to purchase the insurance policy, they would keep their premiums down by maintaining quality. Insurance companies would specialize in monitoring hospitals to know how to price their policies, thereby performing a function that individual patients would find difficult to undertake.

How could this solution be applied to Medicaid patients? Under the current Medicaid program, patients are spending taxpayer money and thus getting no direct benefit from any price reduction.

However, if patients were free to exercise choice under a real voucher system, they might have the opportunity to trade off reduced tort liability protections for expanded benefits. For example, providers might offer a greater range of services if patients agreed to waive their right to bring tort claims and accepted a guaranteed insurance settlement in the manner described above.

Solving the Needs of Underserved Populations with MEZs

The central issues presented in this book are those that are of direct and personal concern to the majority of Americans. Accordingly, we have focused primarily on the problems of middle-income families that live in urban areas, where the potential exists for a competitive market for medical services. However, there are other problems, and one is the delivery of health care in rural areas. Similar, although not identical, problems often exist in low-income areas within large cities. In this section we will take a closer look at the problems of rural health care and discuss ways of solving those problems through the creation of Medical Enterprise Zones.

The Economics of Rural Health Care

Rural areas face important policy problems because of some general economic principles that apply to rural health care in the United States and in almost all other countries. What follows is a brief summary of seven such principles.

1. Both the economics and the technical aspects of the practice of medicine create natural differences between urban and rural health care. The very fact that urban areas are characterized by higher population densities means that certain types of medical services will be found only in urban settings, whether decisions are made through the market or through the political system.

One example is the provision of highly specialized services that meet the needs of a small percentage of people distributed more or less randomly throughout the population. Because it is almost always more economical to bring the patients to the specialized service rather than the other way around, such services tend to be delivered from fixed locations. Because travel to centralized urban settings is usually cheaper and simpler, one would expect the services to be located in urban areas.

Thus, in virtually every country, we would expect to see more physician specialists in urban areas than in rural areas. That is the case in countries with national health insurance, as well as in the United States.[4] In U.S. cities, as Figure 20.1 shows, specialists constitute 62 percent of all practicing physicians. In rural areas, specialists constitute only 43 percent, and the percentage declines with the population size.

A similar principle applies to very expensive medical technology that is designed to meet special needs. One would not expect to find burn centers or organ transplant centers in remote rural villages, for example. Another difference between urban and rural health care services is that services that have large economies of scale tend to be located in urban areas. Taking advantage of economies of scale requires high volume, and high volume typically is impossible in rural areas. Thus, it is not surprising that most full-service hospitals are in larger cities, whereas hospitals in rural areas offer a limited range of services.

In the United States, hospitals with 300 or more beds make up 30 percent of all beds in metropolitan areas, but only 2 percent of the beds in nonmetropolitan areas, as shown in Figure 20.2. Hospitals with 200 to 299 beds make up 20 percent of all beds in metropolitan areas, but only 5 percent of the beds in nonmetropolitan areas. Overall, hospitals with fewer than 100 beds account for almost 75 percent of all rural hospitals, but only 23 percent of all urban hospitals.[5] These differences in hospital types between urban and rural areas persist even though the total number of hospital beds per person is about the same.[6]

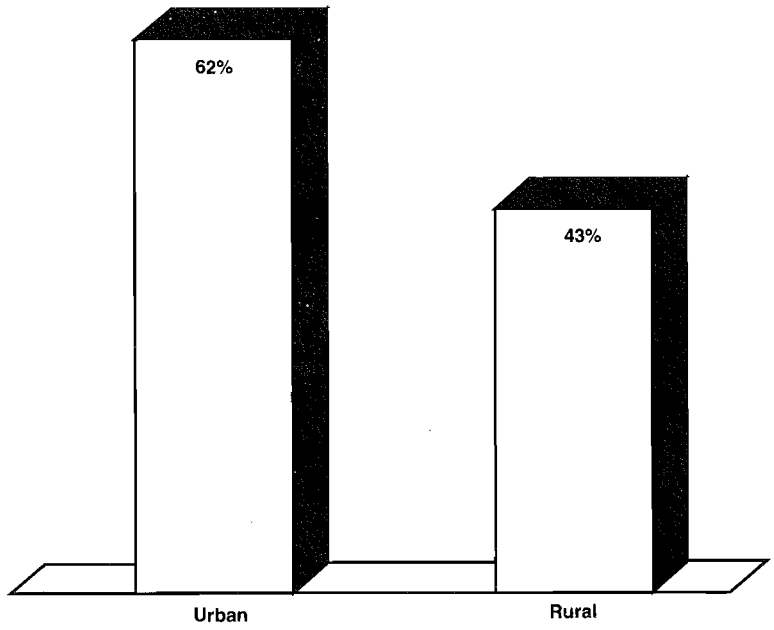
A similar principle often applies to surgery. In general, if a hospital performs a high volume of a particular type of surgery, it will have a lower average cost for providing the service, and it may have

[4]U.S. Office of Technology Assessment, *Health Care in Rural America* (September 1990), Table 10.15 (p. 235). In 1988, about 23 percent of the population lived in nonmetropolitan counties as defined by the Office of Management and Budget. About 27 percent of the population lived in "rural" areas of 2,500 or fewer residents, as defined by the Bureau of the Census. A little more than 15 percent of the population is "rural" by both definitions. See U.S. Office of Technology Assessment, *Health Care in Rural America*, p. 35. In this section, U.S. statistics on rural health care refer to nonmetropolitan areas.

[5]U.S. Office of Technology Assessment, figure 1.3 (p. 12).

[6]Ibid., p. 153.

Figure 20.1
PERCENT OF PHYSICIANS IN URBAN AND RURAL AREAS WHO ARE SPECIALISTS, 1988*



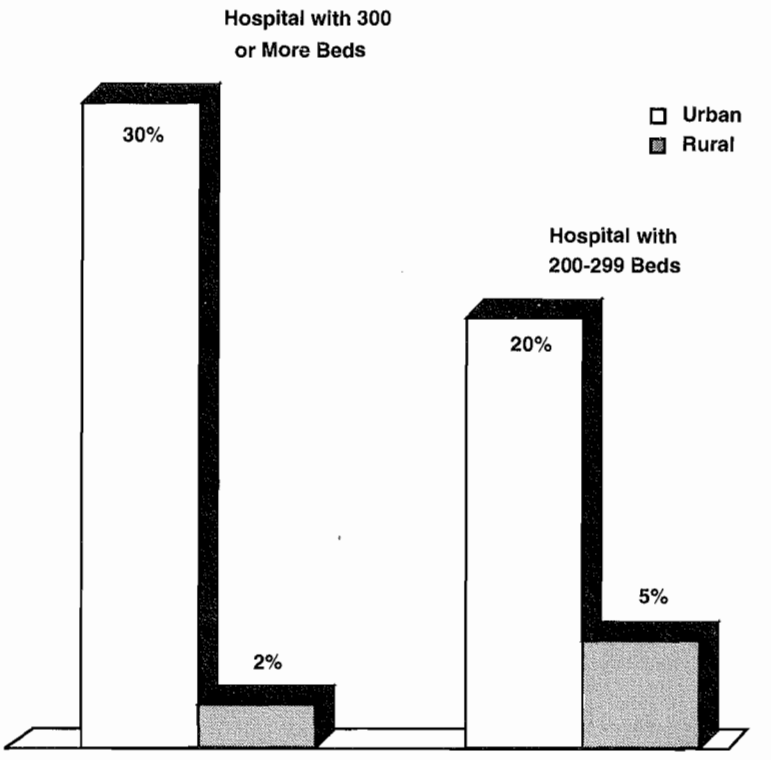
SOURCE: U.S. Office of Technology Assessment, *Health Care in Rural America* (September 1990), Table 10.15 (p. 235).

*Percentages based on total numbers of active physicians in each type of area. Nonspecialist, or primary care, physicians include physicians in general and family practice, internal medicine, pediatrics, and obstetrics and gynecology, and doctors of osteopathy.

a higher success rate as well. As a result, both cost and quality considerations favor the urban hospital setting. For example, one study of U.S. hospitals found that the cost for low-volume hospitals was 50 percent higher for emergency room visits, 150 percent higher for general surgery, and more than 600 percent higher for maternity.[7] Other studies show that mortality rates for surgeries, such as

[7]Thomas G. Cowing and Alphonse G. Holtman, "Multiproduce Short-Run Hospital Cost Functions: Empirical Evidence and Policy Implications from Cross-Section Data," *Southern Economic Journal* 49, no. 3 (January 1983): 648.

Figure 20.2
PERCENT OF HOSPITALS BY SIZE IN URBAN AND RURAL AREAS*



SOURCE: U.S. Office of Technology Assessment, *Health Care in Rural America* (September 1990), Figure 1.3 (p. 12).

*Percentages for each size category based on total number of hospitals in each type of area.

heart surgery, are considerably higher when performed infrequently.[8]

2. The supply of rural health care services is directly related to the national supply of health care services. If a country has only

[8]Warren Greenberg, "Demand, Supply and Information in Health Care and Other Industries," in Jack A. Meyer, ed., *Incentives vs. Controls in Health Policy* (Washington: American Enterprise Institute, 1985), p. 100.

one CAT scanner, the scanner almost certainly will be located in a large city. Only as the number of scanners increases is there an opportunity for rural hospitals to obtain one. The amount of medical technology available to rural communities, therefore, is directly related to the amount of technology available in the country as a whole. A similar principle applies to health manpower. In countries with only a few doctors, both general practitioners (GPs) and specialists tend to be in large cities. Only as the number of providers increases do some of them tend to migrate to rural areas.

In market economies, the process by which expanding national supply affects the supply to rural areas is called diffusion. Resources locate first where they receive the highest rate of return. As more resources become available, competition lowers their rate of return in urban areas, and rural areas, where no competitors exist, become increasingly attractive.

In the United States, for example, the location of physicians can be explained in terms of competition and economic opportunity as well as the underlying preferences of physicians.[9] As a result, an increase in the total number of physicians means more physicians in rural areas. Between 1979 and 1988, the number of patient-care physicians per capita increased by about the same rate in rural areas (23.5 percent) as in urban areas (23.7 percent).[10] The total number of physicians per capita increased by a higher rate in rural areas (24.4 percent) than in urban areas (19.7 percent).[11]

The U.S. experience is not unique. Nor is it confined to the developed world. Wherever the supply of physicians relative to the total population expands, rural areas almost always benefit. For example, as a result of a 25 percent increase in the number of physicians in Canada, the physician-to-population ratio in the underserved provinces rose relative to that of other provinces; in

[9]See L. Jackson Brown and Jack Reid, "Equilibrium and Disequilibrium in Markets for General Practitioners: New Evidence Concerning Geographic Distribution of Physicians," *Advances in Health Economics and Health Services Research* 4 (1983): 305–33; L. Jackson Brown, Jesse S. Hixson, and Gerald L. Musgrave, "Implications of the Expanding Supply of Physicians for Geographic Distribution," unpublished manuscript (1983); and Jesse S. Hixson, "The Spatial and Specialty Distribution of the U.S. Physician Supply," American Medical Association Center for Health Policy Research, Discussion Paper no. 87–9 (October 1987).

[10]*Health Care in Rural America,* Table 10.24 (p. 246).

[11]Ibid.

rural Ontario, the ratio rose between 35 and 80 percent while increasing by 40 percent for the province as a whole.[12] Expansion of the number of physicians in Egypt led to so much saturation in the urban areas that 50 percent of all young physicians are now setting up practice in rural areas.[13] In Malaysia, there is one doctor for every 1,200 people in the capital, Kuala Lumpur, compared with one for every 9,000 people in the rural state of Kelantan. However, expansion in the number of specialists has caused GPs to open 24-hour clinics and to begin relocating in rural villages and on oil palm and rubber estates.[14] Between 1975 and 1985, the number of physicians per capita expanded by 50 percent in South Korea; as a result, the number of rural physicians expanded by 19 percent.[15]

3. As medicine becomes more complex and specialized, urban areas increase their comparative advantage in the provision of many types of care. Even as the expanding national supply of medical services leads to an expansion of services in rural areas, increasing complexity and specialization tend to reverse that flow or at least change its composition. In the field of surgery, for example, outpatient surgery is the least location-bound, and one would expect the availability of outpatient services to grow over time in rural areas. Yet, as more outpatient surgery is performed, surgery performed on an inpatient basis tends to be increasingly complex and specialized. Thus, one would expect the growth of inpatient surgery to occur in urban areas at the expense of rural areas. The U.S. experience bears out this expectation. Between 1984 and 1988, there was a general shift from inpatient to outpatient surgery in almost all areas of the country, but the shift has been more pronounced in rural areas. The number of inpatient days fell by 16.1 percent in rural hospitals, compared with a 10.4 percent drop in urban hospitals, and the number of outpatient visits grew by 33.5

[12]Malcolm Anderson and Mark W. Rosenberg, "Ontario's Underserviced Area Program Revisited: An Indirect Analysis," *Social Science and Medicine* 30, no. 1 (1989): 37, 39.

[13]Julius B. Richmond and Jeremiah Norris, "Egypt," in Richard B. Saltman, ed., *The International Handbook of Health Care Systems* (New York: Greenwood Press, 1988), pp. 73–91.

[14]Ho Tak Ming, "The Present Problems and Future Needs of Primary Health Care in Malaysia," *International Journal of Health Services* 18, no. 2 (1988): 285.

[15]B. M. Yang and J. Huh, "Physician Distribution and Health Manpower Policy in Korea, " *Asia-Pacific Journal of Public Health* 3, no. 1 (1989): 68–71.

percent at rural hospitals, compared with 25.5 percent at urban hospitals.[16] In general, rural communities have more general practitioners and outpatient surgery than ever before. But for specialized care and inpatient surgery, the trend is for rural patients to go to the larger cities.[17]

4. Rural health care is not necessarily less expensive. A common assumption is that because wages, rents, and other input prices tend to be lower in rural areas, the cost of providing health care is also lower. That assumption overlooks two facts. First, many health personnel perceive large cities as having advantages over rural areas and are likely to demand higher incomes to compensate for rural living. The process of diffusion that induces physicians and other personnel to locate in rural areas requires economic incentives. The minimum income needed to retain rural health staff may be higher than that needed for large cities. Second, there are economies of scale in the provision of many health services. If rural practices are unable to take full advantage of these potential economies, their average costs may be higher even when their input prices are lower.

When all factors are taken into consideration, rural health care services cost more than similar services provided in urban areas. A 1987 study by the American Medical Association found that rural family physicians had an average practice cost of $119,000, compared with $92,000 for their urban counterparts.[18]

5. The supply of rural health care services is affected by the size of the market and by competing alternatives. As in any market, potential suppliers of rural health care services can be expected to be guided by their expected rate of return. That return is partly determined by the size, density, and incomes of the patient population to be served. In general, a denser population attracts more physicians. In 1988, rural counties with 50,000 or more people averaged 14.7 physicians for every 10,000 people; by contrast, rural

[16]U.S. Office of Technology Assessment, *Health Care in Rural America,* Table 5.1 (p. 112), Table 5.11 (p. 123).

[17]Ibid., pp. 123–4.

[18]M. L. Gonzalez and D. W. Emmons, *Socioeconomic Characteristics of Medical Practice 1989* (Chicago: American Medical Association, 1989).

counties with fewer than 1,000 people averaged only 5.8 physicians for every 10,000 people.[19]

The amount of money that people are willing to spend on health care rises with income. That makes the wealth or poverty of a rural area an important economic determinant of the size of the market. Not all rural residents are poor, but many are. In addition, rural residents are less likely, on the average, to have private or public health insurance. In the United States, about one out of every six rural families has an income below the poverty line. About 18.2 percent of rural residents have no health insurance coverage, compared with 14.5 percent for urban residents; of people with incomes below the federal poverty level, Medicaid covers only 35.5 percent of rural, compared with 44.4 percent of urban, residents.[20]

Another important factor is the presence of competing alternatives. Although rural areas are often depicted as lacking health care alternatives, more than 84 percent of rural hospitals are actually within 30 miles of another hospital.[21]

6. There is no "right" amount of rural health care, independent of people's preferences. Many health economists who write about rural health care assume that there is a problem that is independent of the preferences of the people to be served. For example, many take the existence of counties without physicians or hospitals as self-evidently a social problem to be solved. But such a view is unfounded. No one is forced to live in "frontier" counties (containing six or fewer people per square mile). People who choose to live there give up a great many of the amenities of urban living, including immediate access to health care. Presumably they prefer the problems of the frontier to the even greater problems they associate with urban life. The right amount of health care in rural areas is the amount that the residents are willing to pay for. If people in rural areas decide to spend less on health care and more on other goods and services, that fact is not a social problem. In the United States we allow the poor and the elderly to purchase health care with public funds. But if rural patients choose to spend Medicare and

[19]U.S. Office of Technology Assessment, *Health Care in Rural America*, Table 10.24 (p. 246).

[20]Ibid., pp. 6, 7, 49.

[21]Ibid., Table 5.42 (p. 148).

Medicaid funds at urban rather than rural hospitals, that is an exercise of patient preference, not a social problem.

7. Survival in the rural hospital marketplace requires businesslike decisions and a willingness to change. An inevitable result of the cost-plus system in the United States is that nonprofit hospitals have not been managed in a businesslike way. As the hospital marketplace undergoes radical change, a businesslike approach to hospital management is becoming evident in competitive urban areas. That is less true in rural areas. Although some hospitals have closed in recent years, there is still an abundance of rural hospital beds. Many existing rural hospitals, however, will not survive unless they adapt to a changing marketplace.[22]

How Government Policy Discriminates against Rural Areas

Between 1984 and 1988, rural hospitals closed at twice the rate of urban hospitals (a 5.5 percent closure rate versus 2.6 percent).[23] Although most people in areas where rural hospitals have closed still have reasonable access to acute care, the future looks bleak. One federal study stated bluntly that "rural . . . hospitals are going broke."[24]

Although the number of physicians in rural areas is growing, rural areas have only half as many physicians as urban areas when measured on a per capita basis.[25] In 1988, 111 counties had no physician, half a million rural residents lived in counties with no physician trained to provide obstetric care, and 49 million people lived in counties with no psychiatrist.

Government policy toward rural health care is somewhat schizophrenic. On the one hand are programs designed to subsidize rural health care through one bureaucracy or another. On the other are government efforts to discourage the development of a healthy private sector in rural health care. What follows is a brief discussion of current policies that discriminate against people who live in rural areas.

[22]Ibid., pp. 12–13; and chapters 6, 7, 8.

[23]Ibid., Table 5-1 (p. 112).

[24]Ibid., p. 8.

[25]Ibid., Table 10-15 (p. 235).

Reimbursement under Government Health Care Programs

Rural practitioners and rural hospitals complain, with some justification, that they are discriminated against under the Medicare and Medicaid programs. For example, the standard diagnosis-related group (DRG) payment that Medicare makes to hospitals was 9 percent greater for large city hospitals than it was for rural hospitals in 1989. After a "wage index" adjustment is factored in, the discrepancy is even larger.[26] Medicare's method of paying physicians relies on "customary, prevailing and reasonable charges." And because the average prevailing charge for a general checkup from a family practitioner varies from $72 in large urban areas to $53 in small rural areas (as of 1987), urban doctors tend to receive about 36 percent more for the same service.[27] Less is known about Medicaid payments, but similar discrepancies are likely to exist.

Some studies claim to justify the payment differentials on the grounds that the cost of inputs for hospitals and physicians is lower in rural areas. But focusing only on input prices may be misleading. Given that rural practices and facilities do not have the same ability to specialize or to achieve economies of scale, costs in rural areas may be higher. In addition, rural doctors and hospitals that have a disproportionately large percentage of Medicare and Medicaid patients may have few opportunities to offset lower government reimbursement by charging other patients more.[28]

More important, the entire practice of basing payments to physicians and hospitals on costs is an unfortunate remnant of the cost-plus system of finance. A better method would be to recognize that the role of government is to give patients spending power. For example, Medicare might make $60 available for a general checkup regardless of where the checkup is performed and also permit patients to add their own money to that amount if needed.[29]

[26]Ibid., p. 64.

[27]Ibid., Table 12-7 (p. 327). Note that physicians practicing in "high priority" rural health manpower shortage areas now receive a 10 percent bonus payment. Special payments are also made to certain categories of rural hospitals. See U.S. Office of Technology Assessment, *Health Care in Rural America*, pp. 61–68.

[28]For a general discussion of physician reimbursement and practice costs, see U.S. Office of Technology Assessment, *Health Care in Rural America*, pp. 325–29.

[29]Current plans are to move to a single national rate for physician payments. But these payments will be adjusted in ways that result in lower payments in rural areas. See U.S. Office of Technology Assessment, *Health Care in Rural America*, p. 68.

Government Controls on Medical Facilities

Numerous federal and state regulations effectively discriminate against rural health care facilities. They include federal Medicare regulations, federal income tax regulations, state licensing requirements, and other state regulations. For example:[30]

- Medicare rules require hospitals to provide 24-hour nursing service by a registered nurse (RN) in each department or unit of the facility, including the emergency room—an expensive requirement for a small multiservice rural hospital.
- Medicare requires hospitals to use licensed laboratory and radiology technicians and to have a full-time director of food and dietary services.
- Medicare requires hospitals to meet expensive fire and safety rules, including having emergency power, emergency water supplies, and corridors of a minimum width.
- Medicare requires extensive and burdensome paperwork (especially onerous for small hospitals without computer hardware, specialized software, or large administrative and technical staffs) and does not reimburse for the cost of meeting the requirement.
- Medicare requires a full-time RN who is responsible solely for the home health service and certified instructors to conduct classroom teaching for home health aides.
- To qualify as a rural health clinic under Medicare and Medicaid rules, a facility must meet burdensome administrative and staffing requirements.
- To qualify as a community health center (CHC), a facility must have a minimum number of patient encounters per physician and administrative costs must not exceed a certain percentage of total costs—standards that many rural CHCs cannot meet.
- Federal income tax law restricts rural facilities from participating in cooperatives and other arrangements that could provide such services as management, laundry, and housekeeping.
- Federal income tax law restricts the ability of hospitals to attract physicians by offering them loans, income guarantees, and other benefits.

[30]Ibid., pp. 181–93.

- Medicare and Medicaid have "antikickback" regulations that prevent hospital-physician joint ventures, physician ownership of hospitals, and other arrangements that might induce more physicians to practice in rural areas.
- State licensing laws often require rural hospitals to have fully equipped operating rooms and a surgical staff—even if the hospital performs no surgery.
- State licensing laws often require hospitals to employ several individuals to perform tasks that one could perform.
- State certificate-of-need laws may prevent rural hospitals from diversifying into new services or converting into a different type of facility (for example, a long-term rather than acute care facility).
- State and local property tax laws often allow exemptions for nonprofit hospitals only if no part of the hospital's property is used for a nonexempt purpose—a restriction that limits the ability of small rural hospitals to minimize costs and seize market opportunities.
- State enabling acts, many of which were passed 50 years ago, may prevent facilities from offering new services such as nonacute care, even though the market has changed radically over time.

These are only a few of the ways in which government regulations burden hospitals and increase their costs. For large hospitals in large cities, many of these burdens are easily met. But for small rural hospitals, they may mean the difference between bankruptcy and survival in a changing health care market.

Controls on Who May Practice

Numerous studies have shown that qualified nonphysician personnel can render many medical services traditionally provided by physicians—and for a lower price.[31] Collectively referred to as midlevel practitioners, they include nurse practitioners, physicians' assistants, certified nurse-midwives, and certified registered nurse anesthetists.

[31]U.S. Office of Technology Assessment, *Nurse Practitioners, Physicians' Assistants and Certified Nurse-Midwives: A Policy Analysis,* Health Technology Case Study no. 37 (December 1986). See also John C. Goodman, *Regulation of Medical Care: Is the Price Too High?* (Washington: Cato Institute, 1980).

Unfortunately, most state licensing laws are so restrictive that these potential providers of medical care are not fully utilized, even when patients would willingly pay for their services. State laws also restrict the activities of other nonphysician personnel, including pharmacists, optometrists, and the following allied health professionals: clinical laboratory technologists and technicians, physical therapists, occupational therapists, respiratory therapists, dental hygienists, dietitians, radiologic technicians, emergency medical technicians, medical records personnel, and speech-language pathology and audiology personnel.[32] In large cities, where the supply of physicians is plentiful, these restrictions may be less serious. But in underserved rural areas, nonphysician personnel may be the only option. Yet state laws continue to restrict the right of rural residents to purchase health care from nonphysicians who are apparently well qualified to provide it.

Medical Education

Since the publication of the Flexner report in the early 20th century, medical education has been tightly controlled by government. How many medical students are trained, where and how they are trained—these are decisions made by the health care bureaucracy rather than in the marketplace. One consequence is that medical education is dominated by an urban bias.

Between 1978 and 1986, the number of medical students from small towns decreased by 15 percent and the number from rural areas by 31 percent, despite the fact that students from rural areas are seven to ten times more likely to practice in rural areas. At the same time, the medical education curriculum is designed to train students to work as specialists in urban areas; residency programs prepare students to work in large teaching hospitals; and federal research grants encourage a focus on special diseases, leaving few funds available for research on family practice and primary care issues.

Creating Medical Enterprise Zones

Most policy proposals for dealing with the problems of rural health care call for more government spending and more bureaucracy. By contrast, the proposals made here call for equal treatment

[32]See the discussion in U.S. Office of Technology Assessment, *Health Care in Rural America*, ch. 10 (pp. 219–84).

for rural residents and the elimination of regulations that reduce access to care, increase its cost, or regulate it out of existence. The general principle is that some care is better than no care. These proposals are intended to apply only to situations in which care is unavailable or delivered with great difficulty. Under current conditions, many rural residents must go elsewhere for medical care. If the alternatives proposed below were available, no one would be forced to use them. Patients could continue to seek care in other areas as they do now. These proposals merely create new options and new opportunities.

Definition of an Underserved Area

Various definitions are now used, any one of which is acceptable.[33] One definition is that an area is underserved if it is 35 road miles from the nearest existing provider. Once an area has been designated as being underserved, its residents would have an opportunity to create a Medical Enterprise Zone (MEZ). Once created, the MEZ would continue in effect at the discretion of the local population, no matter how the area subsequently developed.[34]

Notification

All providers would be required to inform their patients of their qualifications. Notification could be in the form of a written notice when first-visit information is obtained from the patient, plus some visual notice to remind patients.

Professional Liability

In MEZs, patients could legally waive tort regulations. The most that any patient could recover in litigation would be actual economic damages, with no lump sum awards. States could not impose restrictions or costly insurance regulations on providers. If malpractice insurance were required, malpractice carriers could not discriminate against rural providers in rates or other conditions. Criteria for

[33]See Agency for Health Care Policy and Research, "Delivering Essential Health Care Services in Rural Areas: Analysis of Alternative Models," AHCPR Publication no. 91-0017 (Rockville, MD: U.S. Department of Health and Human Services, May 1991).

[34]In defining an underserved area, only full-time providers would be counted. That would prevent physicians or others from interfering with the process of designation by opening an office and seeing patients only one day a year.

malpractice would be adjusted (reduced) by the provider's ability, training, and education.

Licensing

Licensing boards and medical practice acts could not prohibit nurses and other paramedical personnel from performing services as physician substitutes in MEZs. The following describes some examples.

- Registered nurses (assuming a four-year baccalaureate degree, plus five years of experience) and nurse practitioners could prescribe any medicine or perform any operation not requiring a general anesthetic and currently performed by a physician. They could open an independent practice, not requiring the supervision of a physician. They could practice as partners with physicians. They could own any facility in any underserved area. Some RNs would acquire additional certification as physician assistants or nurse practitioners. However, that would not be a requirement.
- Emergency medical technicians (EMTs) and paramedics would be allowed to perform all of the tasks permitted to RNs except nonemergency surgery. EMTs and paramedics could perform surgery in emergency situations. Any person trained in the military as a combat medic would need no further certification to practice.
- Midwives could deliver babies at any MEZ location. An area with a hospital but no physician performing obstetrics could not restrict a nurse-midwife from admitting patients. Home deliveries or deliveries in the midwife's facility could not be restricted.
- Graduate medical students and residents could, on weekends and at other times, be used as respite providers. Residency programs could not discriminate against students who chose to be weekend providers. Such care would be fully counted as certification in their residency programs. They would serve as emergency backup for other providers.
- Foreign-trained physicians licensed to practice in any Western European nation, Israel, Australia, New Zealand, or Canada could enter America without regard to current immigration

limits and practice in an MEZ without further examination or certification.

- Nonpharmacists could open a pharmacy and dispense prescription drugs if there were no pharmacy within the MEZ under the following three conditions. First, the same accounting and recordkeeping for addictive drugs would be maintained, otherwise no special regulations would apply. Second, the pharmacy could renew or refill any prescription not specifically marked nonrefillable. If it were marked nonrefillable, and the physician could not be contacted, the prescription could be refilled until the physician specifically informed the pharmacy to the contrary. Enough medicine would be dispensed to ensure the patient an adequate supply until his or her next appointment. Third, if there were no medical providers in the MEZ, a licensed pharmacist could prescribe any medication, with or without a physician's authorization.
- Any licensed health care professional, physician, nurse, etc. could cross state lines and practice in an MEZ without being reexamined or paying registration or licensing fees.

Medical Education

No state could prohibit the establishment of a nonprofit or proprietary medical school in a Medical Enterprise Zone. Graduates of the school could not be discriminated against in terms of graduate medical education or state licensing. Applicants to these schools could not be discriminated against by any state or federal program. Once opened, the school could not be closed because the area loses its MEZ status.

Medical School Admissions

Medical students from rural areas who contracted to practice in an MEZ for seven years would be classified as minorities for all purposes, including admissions, scholarships, and quotas. These students would be given preference over other minority students who failed to sign the same contract regarding underserved areas.

Facilities

An area qualifying for the right to establish an MEZ would also be one without a hospital within 35 road miles, plus situations in which emergency services are more than 30 minutes away. Once

an area was qualified as an MEZ, the following conditions would prevail:

- No state could require a certificate of need for any facility in an MEZ.
- No state could require accreditation of a facility in an MEZ.
- Physical facilities used as nursing homes could not be regulated more restrictively than rental homes, motels, or hotels—whichever the physical facility most closely resembled.
- Zoning for hospitals or other health facilities would be permissive. In residential areas, great public harm would have to be demonstrated to disallow the construction of a medical facility. Medical facilities could not be restricted in any commercial or agricultural area for any reason.
- Surgery centers and emergency centers could be opened in any MEZ without regard to zoning, building code, Occupational Safety and Health Administration (OSHA), Environmental Protection Agency (EPA), or other regulations.
- Any government-owned building not on the tax rolls and not occupied for three months could be leased at fair market value to any health care provider wishing to use the buildings or space within and able to afford the first month's rent (that is, minimal capital expense). The lease would be renewable at the provider's discretion.
- Public or private insurance companies could not discriminate against a provider or a facility operating in an MEZ.
- Patients would be informed if the facility was nonconforming. They could waive their rights to litigate or could agree to have any awards limited to actual cash damages without regard to pain and suffering.

Medical Laboratories

The laws governing medical laboratories would be amended as follows:

- Medical laboratories could not be restricted in any MEZ.
- Ownership of laboratories could not be limited in MEZs.
- If unlicensed personnel were employed at such laboratories, the patient would be notified and could sign a form of written consent.

Medical Waste

The laws regulating medical waste would be amended as follows:

- State or federal agencies that regulate the disposal of medical waste could not discriminate against MEZs.
- As long as the facility disposed of the medical waste on its own property, no restrictions more severe than for the disposal of other hazardous waste would be allowed.

Blood and Blood Products

The laws governing the collection and distribution of blood would be amended as follows:

- Anyone could open a proprietary blood collection or distribution center.
- The center could establish any standards for donors. They could discriminate for any reason they chose in obtaining blood.
- They could produce blood with a brand name.

Health Insurance

The laws governing the sale of health insurance would be amended as follows:

- Insurance companies selling health insurance in MEZs would not be subject to mandated benefits legislation.
- Insurance policies offered in any other state could be offered in an MEZ without state restriction.
- Insurance policies could not discriminate against providers or patients who practice or live in MEZs.

Loans to Providers or Facilities

Restrictions on loans made by financial intermediaries to health facilities or providers in MEZs would be eliminated. Banks could make loans to directors who open facilities. Credit unions and other organizations would not be restricted by the percentage of their assets loaned to any one facility. State organizations could lend outside of their state or market area. Foreign investors could invest without restrictions. Interest ceilings or usury laws would not apply. Health organizations could issue commercial paper without state restrictions.

State Hospital and Nursing Home Regulations

States could not restrict the operation of a hospital or nursing home in an MEZ. That is, a state could not require that the hospital perform surgery, have a physician on staff, require an RN on duty when there are no patients, or outlaw the use of teenagers to work with patients needing long-term care. States could not restrict the ownership of facilities in MEZs.

VA Hospitals

The administrative regulations of the Department of Veterans Affairs (VA) and the Department of Health and Human Services (HHS) would be amended as follows:[35]

- Nonveterans would be allowed access to VA staff and facilities on a space-available basis.
- Nonveterans covered by Medicare, Medicaid, or Bureau of Indian Affairs programs would pay at the government-established DRG reimbursement rate (not a possibly higher or lower VA cost).
- Veterans could use their VA, Medicare, or Medicaid funds to obtain better quality care at VA facilities.
- Privately insured or private-pay patients would also have access to VA facilities on a space-available basis. Local VA administrators could negotiate prices and fees freely with insurance companies, health maintenance organizations (HMOs), preferred provider organizations (PPOs), civic groups, or employer groups.
- Local VA administrators could open outpatient surgery or direct-care satellite facilities in MEZs. Administrators could also offer extended hours at the main or satellite facility.
- All non-VA funds would remain in the local area and would not be used to lower the government's direct support for VA facilities; rather, they would be used to expand the VA's service to the community at large.
- Local VA facilities could pay bonuses to employees for overtime or duties outside their federal employee job descriptions.

[35]See Bill McAllister, "Nonveteran Health Care by VA Studied: Proposal Intended to Aid Rural Areas," *Washington Post*, August 21, 1991. As with other proposals made here, resistance from special interests is to be expected. See "Plan to Open Hospitals to Public Angers Veterans," *New York Times*, October 27, 1991.

Local VA facilities could hire full- and part-time professional and nonprofessional personnel to help serve the nonveteran clients. The new employees could be employees of the facility rather than of the VA. That would greatly reduce the administrative burden of hiring federal employees.

Pharmaceuticals

State and federal restrictions would be modified for nonnarcotic medicine in the following ways:

- In an MEZ, any pharmaceutical could be prescribed to aid the patient, without government restriction. Currently, many medicines are successfully being used to treat conditions, even though they have not been approved by the Food and Drug Administration (FDA) for that particular treatment. Some government regulators want to abolish that practice.
- Any pharmaceutical available in Western Europe, Israel, Australia, New Zealand, or Canada could be imported for the treatment of any resident of an MEZ. At present, some 1,000 medically important pharmaceuticals are approved in those countries but not yet available in the United States.[36]
- Pharmaceutical manufacturers and others could advertise any legally available pharmaceutical product to any resident of an MEZ. Commercial and medical free speech could not be limited for residents of MEZs.
- The law under which Medicaid regulations effectively discourage pharmaceutical companies from giving discounts would be amended to exempt pharmaceutical manufacturers, wholesalers, and others to sell pharmaceuticals at discount prices to rural health facilities, providers, or pharmacies for use by Medicare, Medicaid, and other patients. Firms offering discounts would not be required to provide them to nonrural organizations or to any other purchasers. Pharmaceutical firms could treat each individual rural area separately on the basis of its special needs.

[36]Jerry L. Schlesser, ed., *Drugs Available Abroad* (Detroit: Gale Research Inc., 1990).

- Other federal and state regulators would be prohibited from enforcing any law that would restrict any suppliers from offering discounts or reduced prices in rural areas. Nor could legislation force rural discounts provided in one area to be provided in any other area.

Medical Reimbursement

The arrangements under which Medicare, Medicaid, and VA patients are reimbursed would be revised as follows:

- Upon the diagnosis of any medical problem requiring hospitalization, the resident of a MEZ would have the option of treatment under the existing law or a one-time cash payment. The one-time cash payment would be equal to the existing DRG reimbursement for the hospital. Thus, MEZ residents would have the funds to seek treatment anywhere they chose.
- If and when DRGs for physician services are developed, the same cash indemnity payment would be allowed.
- Recurring health problems would be covered as they are covered under existing law.

Professional Referral

Given the economic conditions in rural areas, it is likely that health care professionals would develop a financial interest in local pharmacies, laboratories, hospitals, home health services, etc. That is especially true in the transition to and development of new health care services where none existed previously. For example, a physician might loan a hospital money to purchase lifesaving emergency medical equipment. Under current law, the physician could not send a heart attack victim to that same hospital. The law would be amended as follows:

- Medicare, Medicaid, and state legislation could not prohibit health care professionals in an MEZ from referring rural patients to facilities in which they have a financial interest.
- Health care professionals would be required to tell the patient that they have a financial interest in the facility or service, and inform the patient of the availability of other, competing facilities or services.

Public Health Measures

Public health dollars in an MEZ could be spent on a cost-benefit basis. Under the current system, there is a great deal of money wasted that could be spent to meet legitimate health care needs. For example, the regulation of chemicals is increasingly governed by political responses to public fear and hysteria rather than by careful, objective evaluations of the actual risks and benefits posed by the chemicals and their uses.[37]

Outline of a Play-or-Pay Plan

We conclude this chapter by briefly outlining a play-or-pay plan which (1) guarantees universal health insurance coverage, (2) gives choices and options to people who do not have private health insurance, (3) encourages competition in the delivery of health services to those without private health insurance, and (4) empowers local communities and frees them from the arbitrary rules and restrictions imposed by the federal government and state governments.

Local Health Care Agencies

This plan presupposes a change in the federal tax law such that every individual and family would have tax incentives to purchase private health insurance through a system of refundable tax credits. The lower a family's income, the more generous the tax credit would be. People who choose not to purchase health insurance would automatically pay higher taxes (the amount of the credit). These additional tax payments would be transferred to a local health care agency (LHCA) in the community in which the individual resides, and the LHCA would be responsible for providing any uncompensated health care for that individual.

Under this plan, everyone would have health insurance. Those without private health insurance (and who are not covered by a federal health insurance program) would be self-insured for the

[37]See the discussion in Bruce N. Ames, Renae Magaw, and Lois Swirsky Gold, "Ranking Possible Carcinogenic Hazards," *Science* 236 (April 17, 1987): 272; and Richard Lipkin, "Judging Limits of Safety Is a Regulator's Nightmare," *Insight*, May 23, 1988, p. 16. See also the discussion in Bruce N. Ames, testimony before the California Assembly Committee on Water, Parks and Wildlife, October 1, 1986; and Richard Lipkin, "Risky Business of Assessing Danger," *Insight*, May 23, 1988, p. 11.

amount of their personal assets. Once an individual's assets are depleted, the remaining costs would be paid by an LHCA in a manner similar to that in which Medicaid assumes financial responsibility for private-pay patients who enter nursing homes.

How Individuals Join Local Health Care Agencies

More than one LHCA may operate in the same community. When options exist, individuals may exercise choice. The LHCA selected by an individual will receive funds equal to the tax credit the individual would have received had private insurance been purchased.

Every community will have at least one government LHCA. People selecting the government LHCA will receive a government LHCA insurance card and will be entitled by law to the services the LHCA can provide with the tax credit funds. Other LHCAs will be free to operate in the community. However, people must select one. If no choice is made, individuals will be automatically assigned to a government LHCA, and an insurance card will be issued. Every individual will have an insurance card. There will be no uninsured individuals.

Individuals who have dependents may also receive health insurance coverage from LHCAs. Because the tax subsidy will increase with the number of dependents, there will be more funds for their care. Parents will select coverage or noncoverage for their children. Some adults may wish to purchase private enterprise insurance for their children and rely on the government system for their own care. This proposal allows these family-oriented choices to be made.

Nongovernment LHCAs

Any nonprofit organization could become an LHCA. Thus, the Salvation Army, Blue Cross–Blue Shield, the American Association of Retired People, labor unions, and the Red Cross are all potential candidates to operate LHCAs. The services they offer would be determined by contract and there would be an open enrollment period once a year. Every LHCA would have to cover emergency health care. Thus, people who became seriously ill could not be denied care anywhere in the country. Hospitals with emergency care facilities would be required to accept any LHCA insurance card for travelers or those moving to new areas, much as they are now required to provide emergency care, regardless of insurance status.

Nongovernment LHCAs would not be required to provide state-mandated benefits, although they could if they wished. The federal government could not mandate other than emergency and life-threatening coverage for any LHCA, either government or nongovernment.

The plan as outlined thus far, then, formalizes a procedure that is already in place, and improves on the existing system because it provides a mechanism for paying for what was formerly called "indigent health care." It also eliminates free-rider problems because people who choose not to purchase private health insurance would be contributing to their own LHCA health insurance. The amount of contribution would vary by ability to pay.

LHCAs could offer more than emergency care services, moreover. The incentive to do so would be to attract clients and therefore funds. In addition, as nonprofit organizations, LHCAs could accept charitable contributions, which would allow them to provide additional services.

LHCAs and Medicaid

Medicaid patients could be enrolled in government LHCAs, or they might be given the option to enroll in nongovernment LHCAs. LHCAs could not be forced to accept Medicaid patients, however. If they chose to cover Medicaid patients, they would not be required to provide exactly the same services for all members. An LHCA could tailor its services to meet the needs and financing levels for each group. For example, government funding might be higher for Medicaid patients than the tax credit for the voluntarily uninsured. Medicaid might choose to subsidize an LHCA to provide care for the uninsured working poor so that they did not become Medicaid patients. Similarly, all other government programs designed to provide health care to low-income families could also transfer funds under contract to LHCAs.

LHCAs and Welfare

Because of the desirability of community-centered welfare, LHCAs could provide other services in addition to health care. Thus, they might administer AFDC, food stamps, housing subsidies, and other programs. That would encourage the establishment of an integrated approach to meeting the needs of low-income families.

LHCAs and Congressional Districts

One of the dangers of transferring programs from the state and national level to the local level is that little more is accomplished than substituting one bureaucracy for another. How can we be sure that local communities will be more responsive to the needs of low-income families than the current bureaucracy? One way to accomplish that goal would be to create a government LHCA for each congressional district and appoint the member of Congress from that district as the sole trustee. Because elections are held every two years, there would be a single individual who would be answerable to voters for the LHCA's conduct.

Other than providing emergency accident and lifesaving care, the government LHCAs could provide any service, deny any service, and devise any delivery, insurance, or health care system. In their role as trustees, members of Congress could seek advice from health experts, political consultants, and public health officials. They could conduct surveys and obtain information from any source, but that would not be required. The trustees would be treated as if they were federal judges for purposes of litigation if their judgment or behavior were questioned. Upon retirement or defeat at the polls, trustees would, of course, be automatically replaced by their political successors.

Politics of LHCAs

Health care is now a political issue. In our discussion of the politics of medicine in other countries, we demonstrated that one of the worst problems is that politicians seek to distance themselves from the consequences of their decisions (see chapter 18). What is proposed here is to make explicit and open what the political process now must keep implicit and covert. There would be a single individual who would be personally in charge of each LHCA—an elected federal official with sole personal responsibility and few restrictions.

Some politicians will do an excellent job. Their creativity and capability will help their constituents. Other politicians can follow their lead. Being able to run a successful LHCA could be a credential for those who aspire to higher levels of national leadership. Others

will not perform well and will probably be replaced. The competitive process will be good for the nation. Experimentation and variety in meeting public needs are reason enough to adopt this approach.

Solving Problems through Individual Choice and Competitive Markets

The proposals developed in this chapter do not require spending additional money on health care. Instead, they are designed to ensure that money is spent more intelligently and that people have maximum opportunities to use their intelligence, creativity, and innovative ability to solve problems by pursuing their own self-interest with the fewest possible obstacles created by regulatory bureaucracy.

21. Conclusion

The prevailing view in health policy is that markets cannot work in health care. This view has been used to justify the systematic suppression of prices and competition, and their replacement by regulation, bureaucracy, and nonmarket institutions.

Yet a principal finding of this book is that individuals in the medical marketplace exhibit exactly the same self-interested behavior they exhibit in every other market. When consumers face artificially low prices for health care services, they will overconsume those services. If the out-of-pocket cost is zero, they will tend to consume health services until their value at the margin is zero. On the supply side, self-interested behavior also is evident. When suppliers of medical services find that overprovision of services is profitable, they will overprovide. Moreover, they will provide more of those services for which the rewards are high, and less of those services for which the rewards are low.

Virtually every major problem in health policy stems from these elemental facts. Whereas in normal markets the pursuit of self-interest usually leads to desirable social outcomes, in health care the opposite is true. The pursuit of self-interest in health care leads to socially bad outcomes precisely because all of the checks and balances found in other markets have been eradicated or undermined.

Every proposal to solve America's health care crisis with more bureaucracy and more regulation is based on the premise that self-interested behavior can be regulated and controlled, and perhaps eliminated altogether. For example, advocates of universal, free health care are not arguing for a system in which patients are allowed to consume any health service they happen to want without paying for it. They fully realize that without constraints, free health care would bankrupt the nation. Rather, the advocates of national health insurance favor a system of health care rationing, under which patient preferences are largely ignored and medical services

are delivered based on technocratic judgments about medical needs. Similarly, the advocates of national health insurance are not arguing for a world in which physicians get paid for any services they happen to deliver. Rather, these advocates favor a system in which physician preferences are tightly controlled and the supply of health care services follows a national bureaucratic plan.

The assumptions of the advocates of greater government control are false. Self-interested behavior is a normal and natural characteristic of human beings that will be with us always. Socialism does not work in health care any better than it does in any other market. Wherever we find government allocating health care resources, we also find common, persistent patterns. The pressures produced by competition for political office inevitably lead politicians to limit expensive medical technology for the few who need it in favor of marginal services for the vast majority of people who are not seriously ill. Physicians and hospital administrators are invariably rewarded for achieving political goals, not medical goals. And the patients are the losers.

Health care systems ruled by politics are always inefficient systems. They do not deliver high-quality services promptly and efficiently because there is no market mechanism to reward the providers for doing so. The special victims of health care rationing in bureaucratic health care systems tend to be the poor, the elderly, racial minorities, and residents of rural areas. Moreover, all of the characteristics of government-run health care systems in other countries are increasingly evident in our own government programs—especially Medicaid and Medicare—which are answerable to self-interested bureaucrats and politicians.

In this book we have used the term "cost-plus finance" to describe the way in which Americans have paid for health care for the past 40 years. On the surface, this system appears very different from the national health insurance schemes of other countries. On a more fundamental level, however, our health care system shares with the systems of other developed countries one fundamental feature: the lack of a genuine marketplace. Whereas other countries have formally adopted socialism in health care, our preference has been for private-sector socialism. Yet it is increasingly evident that neither public-sector nor private-sector socialism in health care can provide Americans with what they want and need.

A unique feature of this book has been the elaboration of an alternative vision of how the health care system could function. We believe that it is senseless to try to eliminate self-interested behavior from the medical marketplace. To the contrary, self-interest must be channeled and encouraged—to solve social problems in health care the way problems are solved in other markets. That requires transferring money and power from large, bureaucratic institutions to individuals and encouraging vigorous competition in the market for health care services.

The difficulty is in getting from here to there. Before normal market forces can solve our most important problems in the health care sector, the cost-plus system must be dismantled from the bottom up. The most that politicians can do is change the rules of the game. Once the rules have been changed, the tedious process of replacing cost-plus institutions with market-based institutions can begin. But the process of change must itself be market-oriented—brought about by millions of people pursuing their own interests.

Market forces are already at work, chipping away at the cornerstones of cost-plus health care finance. These forces are encountering formidable government barriers. The same public policies that enabled cost-plus health care to flourish are protecting it from collapse and replacement. The urgent need is for a reversal of policies, a removal of barriers to competition in health care. The change must be purposeful, coordinated, and designed to create a new health care system in which the preferences of individuals rather than those of impersonal bureaucracies govern the evolution of the medical marketplace.

The proposals set forth in this book—including a general agenda for solving America's health care crisis, and public policy recommendations in support of that agenda—have been designed to help the United States move to a market-based system. It is unrealistic, however, to expect major political change on the basis of a vision alone. Political change always creates hardship. Therefore, in the very act of changing rules and regulations, politicians must be seen as solving immediate problems, as well as long-range ones.

It is for that reason that the policy proposals have two distinct goals. The first is to solve well-defined, immediate social problems in the health care sector, thus making the proposals politically attractive. The second is to create a public policy framework in

which an ideal health care system can flourish and prosper. The following is a summary of the general changes that are needed and the solutions we developed.

Changes in Tax Law

The U.S. system of paying for health care has, in large part, been created by federal tax law. For that reason, any fundamental change in the way that Americans pay for health care must begin at the federal level. Needed changes would affect the demand for health care and health insurance, as well as the supply.

Income Tax Treatment of Health Insurance

The current federal income tax system favors employees of large companies with benefits that are increasingly unavailable to the self-employed, the unemployed, and employees of small businesses. It is an employer-based system, originally designed to serve the needs of large companies rather than individuals.

If there is any social reason for the federal government to encourage the purchase of health insurance, then favorable tax treatment should be extended to all Americans in an equitable manner. Moreover, the proper federal goal is to benefit individuals over the whole of their work lives, not the particular firms that happen to employ them along the way.

Accordingly, all Americans should receive an income tax credit for health insurance, regardless of who purchases the policy. The tax subsidy should be limited to encourage the purchase of catastrophic, no-frills health insurance, and higher credits (including refundable credits) should be established to make it easier for low-income families to acquire health insurance.

In a competitive insurance market, there may be economies of scale in the purchase of group health insurance negotiated by employers, trade associations, or other groups. The tax law should not ignore this possibility. But the law should also encourage personal and portable benefits, so that health insurance meets long-term individual needs. When policies are purchased by employers, the value of the premium payment should be part of the taxable wages of employees, who would be able to take a tax credit for health insurance on their personal income tax returns.

Income Tax Treatment of Self-Insurance by Individuals

The current federal income tax system encourages the use of wasteful third-party insurance, instead of self-insurance for small medical bills. Although it encourages employers to self-insure for medical expenses, employees are penalized if they do the same thing. To remedy this defect, it should be a matter of national policy to encourage individual self-insurance through Medisave accounts, with third-party insurance being used only for large medical bills. People should receive no tax encouragement for the purchase of low-deductible health insurance. They should receive tax credits (including refundable tax credits) for making deposits to Medisave accounts. The funds in their accounts would grow tax-free and would be restricted to the payment of medical expenses.

Income Tax Treatment of Employee Benefits

At one time, it was thought that the tax laws governing employee benefits would encourage employers to extend health insurance coverage to more employees. Today, such laws are having the reverse effect, as employees of large companies choose not to cover their own dependents and small firms end their health insurance programs altogether. The tax law is so constraining that no insurance is sometimes seen as the best alternative.

To remedy this defect, employee health insurance benefits must be individualized. Employees should be able to exercise the same choices as if they were self-employed. That means they should be able to choose between wages and tax-favored health insurance and among all of the available health insurance options.

Income Tax Treatment of Savings for Postretirement Health Care

As we move into the 21st century, the United States—along with other developed countries—will face a financial crisis of unimagined proportions. Millions of elderly people will continue to look to government for pension income and health insurance. Yet the tax burden required to pay those benefits will take more than half of the average worker's income. This financial crisis will arise because both public and private methods of paying for postretirement health care are based on pay-as-you-go finance.

To avert the financial crisis, the United States must move quickly to a system under which each generation pays its own way. Instead of subsidizing current consumption of medical care and penalizing

savings for future health care, there should be a system that encourages savings. As people age, they typically experience more and more expensive medical episodes. Thus the federal government should encourage the use of medical IRAs (MIRAs) primarily designed to pay medical expenses during retirement. The funds in such accounts would grow tax-free and would gradually substitute for Medicare.

The Role of Public Subsidies

A hallmark of cost-plus health care is the elaborate system of price discrimination known as cost shifting. Historically, in the market for physicians' services, hospital services, and health insurance, some people paid more so that others could pay less. This practice was defended on the grounds that higher income people should subsidize the expenses of lower income people. However, there is no clear evidence that this system really serves the interests of low-income people—or any other well-defined social purpose.

The failure to have competitive prices in the health care sector produces many undesirable side effects. People who are overcharged for medical care may decide not to purchase the services they need. People who are overcharged for health insurance may decide not to buy the coverage they should. The lack of competitive prices also causes individuals and employers to make inefficient decisions with respect to the choice between self-insurance and third-party insurance.

To the degree that prices are competitive (and reflect real production costs), they signal producers and encourage them to innovate and find lower cost methods of supplying those services. If the price system is distorted or if real prices are virtually nonexistent, such important signals will not be present.

The goal of government should be to provide a legal framework that will encourage the development of competitive markets. To the degree that goal is achieved, the United States will enjoy the benefits that competitive markets produce in other sectors of the economy. But because competitive markets are inconsistent with price discrimination and cost shifting, their emergence will force Americans to rethink current public policies.

In a competitive market, if government underpays for services intended for Medicaid and Medicare patients, the services will not

be provided. Hospitals will not be able to overcharge some patients to finance charity care for others, and health insurance companies will not be able to overcharge some policyholders to subsidize coverage for others.

If we adopt the policy of encouraging private health insurance, Medisave accounts, and medical IRAs, we may some day reach a point where there is no need for any further direct role for government. In the meantime, a responsible role for government would be to directly subsidize those needs that are clearly socially desirable. A system of income-related disability payments would help families with preexisting and expensive medical needs that cannot be covered by private health insurance. A system of income-related subsidies to help families purchase health insurance would help high-risk people obtain coverage they otherwise could not afford. Government efforts to assist low-income families should be direct and financed by general tax revenues. As market-based institutions arise to solve problems, the need for government intervention will diminish over time.

Eliminating Harmful Regulations

The medical marketplace is one of the most regulated sectors of the U.S. economy. These regulations are designed to serve as a replacement for the market. Yet all of the evidence points to the conclusion that a regulated, bureaucratic health care system is no substitute for informed consumers making decisions in a competitive marketplace.

Regulation of Physicians

Today's physicians are buried under a mountain of paperwork, red tape, and bureaucratic regulation. Partly as a result, applications to medical schools have declined almost steadily since the mid-1970s, and 40 percent of physicians doubt that they would go to medical school if they had to do it all over again. Increasingly, the practice of medicine is dictated by third-party payers to the detriment of good-quality medical care and the doctor-patient relationship. And success in medical practice is now determined by the ability to manipulate third-party reimbursement rules rather than by the ability to meet patient needs.

Almost all of the burdensome rules and regulations are related to the third-party payment of medical bills. Most of them would be

unnecessary and irrelevant if patients were spending their own money. Thus an important benefit of the changes described above is that they would empower patients and diminish the role of third-party payers. Government should provide information and prevent criminal and civil fraud, but there is no need for government to dictate the price and quality of medical care.

Regulation of Hospitals

The hospital sector is the most regulated of all health care sectors. As a result, the hospital marketplace is a bureaucratic, institutionalized market in which prices do not allocate resources or reflect real costs. As in the case of the regulation of physicians, the vast majority of the hospital regulations are a result of third-party reimbursement. Some fear that future survival in the hospital market will depend more on skills at manipulating reimbursement formulas than on adopting efficient production techniques. Nowhere are the harmful results of the cost-plus system more evident than in the problems confronting patients, who ultimately make the purchasing decisions in the hospital sector. Patients rarely can find out the price of a procedure before "buying" it and usually receive line-item bills that neither they nor their physicians can understand.

Public policy should encourage a competitive market in which hospitals announce their prices up front for common procedures, so that patients can become informed shoppers in the hospital marketplace. The mere act of empowering patients will probably do more than anything else to cause change. As the market for cosmetic surgery shows, competitive pricing emerges quickly when third-party payers are not a factor.

Regulation of Health Insurance

Insurance for medical expenses does not function the way other insurance does. Whereas life insurance and casualty insurance protect consumers against the financial burdens of risky events, health insurance is largely prepayment for the consumption of medical care. Consumers are worse off as a result. Because health insurers are prevented from pricing risk accurately, individuals are making decisions with adverse social consequences. Healthy individuals who find they are being overcharged are declining to buy insurance, thereby adding to the ranks of the uninsured. State legislatures are pricing millions of people out of the market through mandated

health insurance benefits, premium taxes, and risk pool assessments. Perhaps as many as one out of every four people who lack health insurance has been priced out of the market by these cost-increasing regulations.

When markets were more competitive and health insurance more closely resembled real insurance, a strong market for individual policies existed. Health insurers often sought out people in risky industries, and policies were usually guaranteed renewable. Today, an increasing number of large health insurers refuse to sell individual policies, and the small group market is in danger of collapsing. Although prepayment for the consumption of medical care is at least a possibility for large corporations, it is virtually an impossibility for individuals and small groups.

The most common proposals for health insurance reform promise more of the same. They would move the country in the direction of a one-price-fits-all approach, in which price and risk would be completely divorced. Legislators would dictate health insurance benefits based on special-interest pressures from providers, rather than on consumer preferences revealed in the marketplace. The urgent need is to move in the opposite direction. People should be free to purchase no-frills catastrophic health insurance, making selections among policies based on individual and family needs. Insurers should be able to offer real insurance and specialize in the traditional insurance function of accurately pricing risk.

Empowering People Covered by Government Health Care Programs

Government, both directly and indirectly, is responsible for more than half of the nation's health care spending. Moreover, the government sector is the fastest growing component of the health care system. It is also the source of some of the most critical health policy problems.

Because the supply of health care services is relatively inelastic, when government programs expand, each additional dollar of spending buys only 35 cents of real services. The remainder is consumed by inflation. When government expands benefits but refuses to pay for them, the result is cost shifting to the private sector, in addition to accelerating medical inflation. As government imposes more and more cost controls, the result is health care

rationing for those that government programs were supposed to serve.

Medicare and Medicaid

Medicare and Medicaid are not just two more buyers in the medical marketplace. Through them government uses its monopsonistic power to dictate price and (indirectly) to dictate quality. Physicians and patients are virtually powerless to change the terms of the arrangement even if patients would clearly benefit. As a result, these programs are increasingly causing medical care to be rationed.

A major step toward empowering patients and freeing the marketplace would be to restrict Medicare and Medicaid to the original goal of providing funds for the purchase of medical care. Accordingly, these programs should limit the amount that government will pay for medical services, but leave patients completely free to negotiate the total price for the services they receive. An equally important step would be to reduce the role of government as a health insurer. Government can provide funds for the purchase of health insurance without providing health insurance itself. Accordingly, private insurers should be able to offer Medicare and Medicaid patients alternatives to the current one-size-fits-all programs. Government can empower people in the market for health insurance without regulating and controlling that market.

Over the long run, Medicare can and should be replaced with individual savings through medical IRAs (MIRAs). Medicaid can be greatly diminished in size through refundable tax credits for the purchase of health insurance and the establishment of medical savings accounts for low-income individuals.

Reestablishing the Safety Net

Other changes in the public sector are also needed, and the most important changes do not require more government spending. Medical Enterprise Zones (MEZs) and Medical Enterprise Programs (MEPs) would remove bureaucratic obstacles and allow rural residents and the urban poor access to the benefits of a competitive medical marketplace. In most cases, turning control of public health care dollars over to local communities would ensure that the same money would go further in meeting real needs.

At the same time, we need a national commitment to a fair and equitable method of paying for indigent health care. If every

nonelderly family in America had the opportunity to receive a tax benefit for the purchase of health insurance, people would be free to make rational choices. Those who chose not to purchase health insurance would pay higher taxes. But those tax dollars should then be returned to local communities to pay for what is now uncompensated care for the uninsured.

Planning for the Future

If the recommendations above are adopted as national policies, virtually all the legal protections presently accorded to the system of cost-plus health care finance will have been removed. In response to these policy changes, market-based institutions will replace cost-plus institutions very quickly. What we have called an ideal health care system will rapidly emerge, and the market for health care will resemble other markets.

What will the new health care system look like? Although no one can be sure of the details, such a system is likely to solve the problems of ordinary people as well as major social problems in the health care sector. In the new medical marketplace, power will be transferred from huge bureaucracies to individuals acting on their own behalf. Patients rather than third-party payers will be the principal buyers of health care. Physicians will be the agents of patients. Hospitals will be businesses selling services to patients and physicians. Insurance companies will be insurance specialists only. Government will be simply a mechanism by which individuals become informed consumers in the medical marketplace.

No one can predict the changes that will take place in medicine in the 21st century. Fifty years ago, the most creative science fiction writers did not even come close to imagining what the practice of medicine would be like in the 1990s. Over the next 50 years, the changes almost certainly will be even more dramatic.

Our generation has the opportunity to build a framework that will enable future generations to cope with the advances of medical science, whatever they may be. That is the legacy we can leave to our children, to our grandchildren, and to all others who follow.