PATIENT POWER

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To Jan and Jeanette

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Preface

The thesis of this book is simple: If we want to solve the nation's health care crisis, we must apply the same common-sense principles to medical care that we apply to other goods and services.

In a 1991 *New York Times*/CBS News poll, almost 80 percent of the respondents agreed that the American "health care system is headed toward a crisis because of rising costs."[1] The irony is that health care costs are rising because, for individual patients, medical care is cheap, not expensive.

On the average, patients pay only 5 cents out-of-pocket for every dollar they spend in hospitals. The remainder is paid by private and public health insurance. Patients pay less than 19 cents out-of-pocket for every dollar they spend on physicians' services, and they pay less than 24 cents out of every dollar they spend on health care of all types. Patients therefore have an incentive to purchase hospital services until, at the margin, they're worth only 5 cents on the dollar and to purchase physicians' services until they are worth only 19 cents on the dollar. The wonder is that we don't spend even more than we do.

Health care is often said to be a necessity. However, there are other necessities such as food, clothing, housing, and transportation. If we paid for any of these items the way we pay for health care, we would face a similar crisis. If we paid only 5 cents on the dollar for food, clothing, or housing, for example, costs would explode in each of those markets.

If we are to control health care costs, we must be prepared to make tough decisions about how much to spend on medical care versus other goods and services. So far, we have avoided such choices, confident that health care spending can be determined by "needs," rather than by choices among competing alternatives. In this respect, the U.S. health care system is unique. The United

[1]Erick Eckholm, "Health Benefits Found to Deter Job Switching," *New York Times*, September 26, 1991.

States is the only country in the world where people can consume medical care almost without limit, unconstrained by market prices or by government rationing.

Consider the case of an 80-year-old man who suffered from the condition of "slowing down." Despite the physician's counsel that the condition was perfectly normal at age 80, the patient and his wife went on a literal shopping spree in the medical marketplace. As the physician explained to the *New York Times:*

> A few days ago the couple came in for a follow-up visit. They were upset. At their daughter's insistence they had gone to an out-of-town neurologist. She had wanted the "best" for her father and would spare no (Medicare) expense to get it. The patient had undergone a CAT scan, a magnetic resonance imaging, a spinal tap, a brain-stem evoke potential and a carotid duplex ultrasound.
>
> No remediable problems were discovered. The Medicare billing was more than $4,000 so far . . . but they were emotionally exhausted by the experience and anxious over what portion of the expenses might not be covered by insurance.
>
> I have seen this Medicare madness happen too often. It is caused by many factors, but contrary to public opinion, physician greed is not high on the list. I tried to stop the crime, but found I was just a pawn in a ruthless game, whose rules are excess and waste. Who will stop the madness?[2]

The potential demand for health care is virtually unlimited. Even if there were a limit to what medical science can do (which, over time, there isn't), there is an almost endless list of ailments that can motivate our desire to spend. About 83 million people suffer from insomnia, 70 million have severe headaches, 32 million have arthritis, 23 million have allergies, and 16 million have bad backs. Even when the illnesses are not real, our minds have incredible power to convince us that they are.

If the only way to control health care costs is to have someone choose between health care and money (that is, other goods and services), who should that someone be? There are only two fundamental alternatives: The choices must be made either by the patients themselves or by a health care bureaucracy that is ultimately

[2]Elliot Rosenberg, letter to the editor, *New York Times,* September 18, 1991.

answerable to government. This book makes the case for the patients.

Almost all arguments against empowering patients are variations on the notion that individuals are not smart enough or knowledgeable enough to make wise decisions. But if that argument is persuasive in health care, why isn't it equally persuasive in every other walk of life? With respect to almost any decision we make, someone else is always smarter or more knowledgeable than we are. If the case for freedom rested on the assumption that free individuals always make the best decisions, we would have discarded liberty and democracy long ago.

The case for empowering patients rests on a different assumption. No one cares more about us than we do. Thus, while prudent people seek and get advice from specialists before making many decisions, it does not follow that we should turn over control of our lives to the experts. In the long run, more good than bad decisions are made when self-interested individuals are free to accept or reject advice from many quarters.

A corollary to the goal of empowering patients is the goal of creating competitive markets in the health care sector, for physicians' services, hospital services, health insurance, and other services. Individuals pursuing their own interests in a market are best served by suppliers who compete vigorously to meet consumer needs with high-quality services produced at the lowest possible cost.

This book represents a radical departure from what is considered normal and acceptable in the field of health policy. Whereas the vast majority of health policy commentators take a bureaucratic approach to health care, our approach is individualistic, focusing on the decisions that individuals make and the incentives they face when they make them. Whereas the vast majority of health policy proposals call for more regulation and more government spending, we find that government is the problem, not the solution—that solving America's health care crisis requires undoing the harmful distortions introduced into the system by government and that only a market-based system will work.

The dominant view of health policy is regularly reported in the national news media and parroted by syndicated columnists, editorial writers, and politicians. What is needed in health care, they

tell us, is not competition, but monopoly. Instead of empowering individuals, they assert, we should empower the bureaucracy. Rather than look to the private sector for solutions, we should look to government. When speaking to the general public, the socialism-works-in-health-care crowd points to national health insurance in other countries, arguing that the quality is high, the cost is low, and the vast majority of people like it. Behind closed doors, though, they tell politicians that other countries control health care costs by refusing to spend money and by forcing doctors to ration health care.

It is no surprise that most people who live under national health insurance like it. For minor aches and pains, they have no difficulty seeing general practitioners and they perceive such services to be "free." But that's not a useful test of a health care system. In any given year, only about 4 percent of the population require access to the remarkable advances made possible by modern medical science. The better test is: When people need such services, can they get them? And if they do get them, how long do they have to wait? It is in answering these questions that we uncover the worst tragedies of socialized medicine.

Two recent news items underscore the potential horror of combining medicine and politics. One story comes from South Africa, the other from newly liberated Romania.

When South African anti-apartheid activist Stephen Biko was imprisoned in 1977, he died after sustaining multiple head injuries. The physician who examined and failed to hospitalize Biko was subsequently disciplined for "disgraceful" conduct. Much later, in explaining his actions, the physician wrote:

> In reflection on the cause of this failure, I came to realize that, over the period of the 30 years I had been employed by the state as a district surgeon, I had gradually lost the fearless independence that is required of a medical practitioner when the interests of his patient are threatened. I had become too closely identified with the interest of the organs of the state.[3]

Medicine controlled by the state ultimately serves only the state.

[3]Reprinted in Benjamin Tucker, "An Apology on Biko," *New York Times*, October 24, 1991.

After Romania's communist regime fell in 1989, Americans saw photographs of Romanian hospitals. On the one hand, a modern hospital with the latest technology and luxury conveniences was reserved for Communist party officials and key bureaucrats. On the other hand, hospitals for ordinary people were operated out of World War II army barracks. Bureaucratic medicine ultimately serves only the bureaucrats.

Most people in the health policy community recoiled in horror at these two revelations. Yet they failed to grasp the underlying lesson. The difference between the Romanian health care system and the systems of most other countries is one of degree, not of kind. The difference between Stephen Biko's treatment and that of victims of government-sanctioned health care rationing in other countries is also one of degree, not of kind. These tragedies represent the ultimate, logical consequences of a goal that is almost universally accepted by health policy analysts: the complete elimination of markets, prices, competition, and choice from the health care sector.

The medical marketplace today is far from normal. In a normal market, producers search for ways to satisfy consumer needs for a price consumers are willing to pay. Demand is a given. The problem for producers is to reduce the costs of meeting that demand. In health care, the opposite is true. All too often, consumer preferences are regarded as irrelevant. Producers decide what their costs are going to be and then wrestle with getting consumers to pay those costs—through out-of-pocket payments, through employers and insurance companies, or through the government.

In a normal market, increases in sales are universally regarded as good. The more consumers buy, the more their needs are being met. If domestic automobile sales increased each year as a percent of our gross national product, most people would cheer. In health care the opposite is true. The annual increase in health care services is viewed not as a benefit, but as a burden.

In the topsy-turvy world of health care, what would normally be viewed as "good" is considered "bad," and vice versa. Thus, in order to truly understand the medical marketplace, we have to discover all of the ways in which normal market forces have been undermined.

In this book we use the term "cost-plus finance" to describe the predominant way in which we are paying for medical services. Our

goals are (1) to describe the cost-plus system of health care finance—how it works, how it evolved, and how we are living with it today; (2) to show how the cost-plus system is creating America's current health policy crisis; and (3) to show how we can move from cost-plus to a system that will solve the majority of America's health policy problems.

In Part I, we describe how recent changes in our health care system threaten the quality of care patients receive and why this is a natural and inevitable consequence of the way we pay for medical care. We show that most of the major problems in health care are the consequence of unwise government policies, and how those problems could be solved by adopting better policies. These policy changes, however, require a clear vision and a commitment to replacing cost-plus medicine with a competitive medical marketplace in which patients, rather than bureaucracies, are given the freedom to make all of the important decisions.

In Part II, we consider how the cost-plus system evolved, with special attention to the enabling role of public policy. We examine its operation prior to the 1980s and the changes that are undermining it today.

In Part III, we examine the role of government policies in the 1980s—the cost containment stage of cost-plus medicine—with special attention to the role of special interests that have shaped and molded cost-control strategies. Part III also examines how millions of Americans have been closed out of the health insurance market, and examines some misguided proposals for addressing those problems through even more regulation.

Part IV examines the one sector of the medical marketplace that is completely dominated by government: health care for the elderly, a sector with almost unlimited potential for future spending.

In Part V, we examine how other countries have responded to the crisis of cost-plus medicine through rationing and the political allocation of health care resources. Special attention is given to what those systems mean for patients and what Americans could expect if this country adopted a system of national health insurance. Even though the cost-plus system is quasi-governmental, we argue that the effects of explicit government allocation of health care resources are much more harmful to patients and much more wasteful. We

also discuss why many of the political pressures that guide decision-making in other countries are already apparent in Medicare and other government health care programs.

In Part VI, we conclude by summarizing the international trend away from socialism in health care and by proposing some innovative solutions to the special needs of underserved groups in our society.

In writing this book, we have benefited from the insights of a very small group of health policy researchers—scholars who have courageously resisted the collectivist assault on our health care system. We extend special thanks to Jesse Hixson (American Medical Association Center for Health Policy Research) for helping us to develop the concept of the Medical Savings Account; to Peter Ferrara (Cato Institute) and Richard Rahn (Novecon Corporation) for helping us to develop the concept of the Medical IRA; to Aldona and Gary Robbins (Fiscal Associates, Inc.) for their analysis of Senator Kennedy's proposal to mandate employer-provided health insurance and of the cost to private industry of national health insurance; to Dale A. Rublee and his associates (American Medical Association Center for Health Policy Research) for their analysis of foreign health care systems; to Patricia Danzon (Wharton School of Business, University of Pennsylvania) for her analysis of administrative costs; and to William J. Dennis, Jr. (The NFIB Foundation) for his analysis of the health care plan proposed by the Democrats in the U.S. Senate.

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In formulating private-sector solutions to our nation's health care problems, we received valuable input from an informal health care task force.[4] In addition to the health policy analysts listed above, we

[4]The informal task force ultimately led to a formal publication which was not necessarily endorsed by all of the individuals listed here. Task Force Report, *An Agenda for Solving America's Health Care Crisis*, NCPA Policy Report no. 151 (Dallas: National Center for Policy Analysis, May 1990). Institutional affiliations were current as of the time of the task force.

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Although we acknowledge help from many quarters, we alone take responsibility for the final manuscript.

A final note to the reader: Some of the material presented in this book is discussed in more than one chapter. Our goal was to make each chapter reasonably self-contained, so that readers interested in some particular aspect of health policy could read our chapter on it without the necessity of reading all of the other chapters. This added convenience for some readers creates a small, but necessary, burden for others due to a certain amount of repetitiveness. Readers will also find in chapters 3 and 4 a summary of all of the major policy recommendations made in this book and an explanation of how those policy changes would solve our most pressing problems.