MEDICAL CARE IN THE UNITED STATES: AN ANALYSIS OF THE CURRENT SYSTEM AND A PROPOSAL

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Abstract

This paper addresses how to reach the goal of assuring access to medical care for all Americans and how to rein in the continuing rise in costs of medical care. The paper documents the deficiencies of the current medical system and its financing. It explains why a managed economy through centralized control cannot direct a complex system of interrelated activities. The paper opposes the Clinton Administration's "managed competition" on the grounds that it is centralized planning for one-seventh of the U.S. economy and will not work.

In common with the Clinton Administration's plan, the authors emphasize the importance to consumers (patients) of information on prices and quality of care for competitive markets to work. We urge major reform of Medicaid because regulation has made it more costly on a per capita basis than the average per capita U.S. cost of medical care. We support "medical IRAs" and also vouchers for persons with low incomes. We also support the phase-out through caps on the employer's income tax deductibility of health insurance premiums and development of catastrophic health insurance.

The rate of annual increase in real national medical expenditures has been falling since 1980, from 3.6 percent during 1970-1980 to 2.3 percent, 1980-1990. We have already reduced the rate of increase from over three times the general inflation rate to just over two times the general inflation rate.

Keywords: capitalism, consumer, costs of medical care, information, managed competition, Medicaid, "medical 'IRA'," voucher.

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The purpose of this article is the need for insight into reasons for and the solution to the soaring costs of medical care. It is claimed that a crisis therefore exists in the delivery of medical care, in particular for the 35 million Americans who lack health insurance. Priced out of the market are the 30 percent of the uninsured who are poor but there are also nearly 4 million uninsured whose incomes are above $50,000 a year.[1] But lack of health insurance is not the same as no access to medical care. Access to medical care for emergencies is almost universal within the United States and to claim otherwise seems to simply be a contrived political stance based on anecdotal information.[2] Lack of health insurance coverage for the 30 percent who are poor may mean, however, limited access for nonemergency care that can add to the costs of their care. But revamping Medicaid, not the whole system, may, as we later propose, be a better solution. Furthermore, the issue is clouded by the inclusion of data which reflects the influence of life style on "health," again a separate issue from "medical" care. Clearly, any action taken can be justified only if it strengthens, not weakens, our current system.

The battle being waged over the control of medicine replicates in miniature the ongoing struggle in the wider society. It is a struggle between government coercion and individual liberty. To paraphrase Vaclav Havel, those who oppose or fail to support the fundamental importance of openness, tolerance and respect for human rights gradually reduce the vital energy, diversity, and unpredictability of American society, including medicine, to a state of dull, inert uniformity.[2] In medicine it

is a contest between a centralized (bureaucratic) system where the patient becomes a pawn, where costs tend to accelerate beyond control and scientific advancement becomes an unrealistic dream, and on the other hand, an already evolving, freely competitive market that would eventually give the welfare of the patient top priority, respect the rights of patients, and result in affordable costs while permitting continued advancements in the quality of care. Even the past editor of the New England Journal of Medicine, Arnold Relman, in a recent critique of managed competition, recommended alternate versions "that would **put the responsibility for the cost and quality control where it belongs - on physicians and their patients.**"[3]

THE CURRENT MEDICAL CARE DELIVERY SYSTEM

In contrast to what is commonly assumed, the delivery of medical care in this country is not controlled by natural market forces. It is a managed economy. This has occurred because our methods of medical care reimbursement were originally established to benefit providers, not patients, and such methods contain no mechanism to control costs. Under our health insurance system the out-of-pocket payments by consumers are far less than the costs of the resources used in their medical care. After meeting the deductible, most patients buy medical care for 20 cents on the dollar. Patients usually do not know the prices and costs of their medical care beforehand. Thus rising prices and costs do

not, as in competitive markets, restrain consumer demand for medical care. Therefore, an increase in providers, especially physicians who are specialists who may order more "high-tech" procedures does not lower costs but leads to increased services, although often of higher quality.

The system of payment in medicine has been distorted by the introduction of employer-paid medical benefits during World War II and by government payments under Medicare and Medicaid enacted in 1965. Demand has been supported and charity care largely eliminated although under-compensated care under Medicaid may be widespread.

Medical costs have risen continually since World War II, but at a decreasing rate in recent years. The rate of annual increase in national medical expenditures has been falling since 1980. Real national medical expenditures rose at an average annual rate of 3.6 percent during 1970-80 and at a lesser rate of 2.3 percent for 1980-90.[6] Spending increases therefore, have decreased substantially even though the costs are still too high, and rising too fast. This suggests that market forces have already begun to restrain costs.

Annual administrative costs have been estimated at $80 to $100 billion. In 1992 the average per person expenditure for medical care was $3098 ($2,747 for personal medical care).[4] Total medical care costs are approaching 14 percent of our relatively stagnant gross domestic product (GDP). Should recent spending trends continue through the year 2000, the <u>monthly</u> cost of family coverage has been projected to exceed $1,100 in 1991 dollars.[5]

But a full time worker, at minimum wage, earns only $8,840 a year, $4,360 short of the total medical care costs projected! No wonder the government, state as well as federal, has promulgated a torrent of regulations and controls.

The 20-cents-on-the-dollar payment for medical care creates distortions with over allocation of resources to medical care, possibly at the expense of education and food. Currently, nearly 500 Diagnostic Related Groups (DRGs) determine hospital reimbursement under Medicare and we can envision thousands more for physician services, x-ray tests and other medical procedures, such as radiation treatment. These are administered prices, not market prices.

The Clinton Administration's proposed "managed competition" would officially create centralized planning for one-seventh of the U.S. economy. By the clever appropriation of the word "competition" in its label, it disguises its purpose: It is centralized planning <u>against</u> competition, not for making competition more effective. U.S. medical care is the last bastion of a relatively free market of medical care. Competition is effective in distributing scarce resources to meet consumer needs only if consumers, not government officials, choose what they want.

Can government direction actually lower per capita costs without dampening the continuing upsurge in modern medical innovation? Can it control costs and cover 35 million individuals without medical insurance coverage?

PHILOSOPHIC ISSUES

Market Economy

A market system requires consumers who search for the best bargains. This stimulates competition and lower prices. In medicine, only the patient can play the role of consumer in the traditional sense. The patient, however, has been removed from the watchdog, consumer role by third parties that pay the bills. As a result, most patients have relatively little interest in the cost of medical care. Consequently, providers, including hospitals, laboratories, physicians, therapists, suppliers, and others have more incentive to increase prices (and costs), than to lower prices. Even today, patients do not continually inquire and/or complain about the cost of medical care. This creates a more pleasant environment for the physician because most prefer to concentrate on the patient's medical problems and let others worry about finances.

The only way to lower the cost of medical care in this country, while simultaneously maintaining high-quality care, is to give medical care consumers an incentive to worry about prices. Therefore, <u>patients, not third parties such as government or private business, must control the purse strings</u>. When patients become concerned about the prices (because they pay the bills directly), physicians will become concerned about costs. And physicians are in a position to help patients influence all other groups that generate medical bills. Physicians can refer patients to alternate providers or suppliers, they can alter diagnostic and

treatment plans, and they can help patients help themselves.

Competitive markets through the price system determine the most efficient allocation of resources for production of goods and services. The activation of market forces is the only way to determine the specific medical benefits most desired by individual patients. Under competitive market forces, the physical and organizational structure of our medical care delivery system would probably undergo significant change in order to deliver better service at minimum cost. There would be no need for a new federal bureaucracy to determine which medical benefits will be available to patients. Planners can prevent such changes, but there is no way to predict them.

For a market to work most effectively, patients need better information on prices and on quality than has existed heretofore. Appropriate mechanisms are already developing. For instance, Pennsylvania's Health Care Cost Containment Council has ranked and published names of cardiac surgeons by patient mortality rates, severity-adjusted, with average charges of their selected hospitals.[19] Computers and consumerism permit business firms that are the major payers to make information on comparative costs and quality of regional hospitals increasingly available to their employees. Today pre-admission package prices that include surgery are, despite objections by some, being negotiated and publicly quoted, as for cardiovascular surgery.

If informed consumers paid their own medical care bills, prices not only would stop rising, they would decrease, possibly by 25 percent overall. The trend is known, but the degree of fall

is not known. Blue Cross of California has already cut reimbursement to surgeons for some procedures.

It is frequently stated that market forces do not work when applied to medical care because medical treatment is too complex for a patient to understand. However, the patient does not need to understand how a medical treatment works, but only the outcome in regard to function and continuing life. For example, millions fly in airplanes but they do not know why or how the airplane flies. It is also stated that market forces are inappropriate because the emotional nature of illness leaves patients defenseless and gullible, a disadvantage when confronting physicians. But patients purchase plastic surgery out of their own pockets. It is often risky, yet the market is thriving.

In summary, a market system can be seen to function like a complex, effortless mechanism in the absence of any visible method of guidance. A competitive market accommodates millions, even billions of individual actions and details, actions which are simultaneously the resultant of, and the guide for, all of the individual decisions that are made. Without purposeful direction, it leads to spontaneous order. Thus, the secret of a market system is its ability to function automatically, in adapting to change.

Managed (Controlled) Economy

The increasingly oppressive actions of a managed economy (a socialist system) were predicted years ago by The Nobel laureate, Friedrich Hayek, in his book, The Road to Serfdom, 1944, the book

that has become the bible for much of Eastern Europe as well as other countries in their quest for market economies. Hayek warned that ". . . the substitution of central planning for competition would require central direction of a much greater part of our lives than was ever attempted before. It could not stop at what we regard as our economic activities, because we are now for almost every part of our lives dependent on somebody else's economic activities."[7]

A managed economy is based on centralized control, which means that ultimate responsibility and power rest in the hands of the person(s) in charge. Decisions are made by a small core of individuals who then issue appropriate guidelines and regulations. As the system matures, it becomes increasingly important that individuals adhere to the guidelines, both for economic reasons and in order to run an efficient, trouble-free operation. Therefore, dissension among the regulated leads to greater coercion and to penalties for detractors. This scenario is identical to that of medicine today, yet it was outlined in detail by Hayek almost 50 years ago.

For anyone who doubts the inevitable course of an authoritarian system of medical care, consider Medicaid, a program established in good faith by planners to provide medical care for the needy. This program covers 31.6 million individuals, mainly children and younger adults, a group where medical care costs are considerably lower than for an older population. The cost of Medicaid had in recent years been ballooning by 20 to 30 percent annually, reaching $119 billion in 1992. This translates into a

per capita cost of over $3,700 per person, which exceeds the per capita cost of personal medical care for the population as a whole ($2,747 in 1992).[4] Even when the $119 billion is adjusted to exclude the costs and numbers of the 160,000 mentally retarded individuals, confined in intermediate care facilities, at close to $50,000 per person, the per capita cost of Medicaid remains well above the cost of medical care per capita in the entire nation.

There are many reasons for the surge in Medicaid's cost in recent years, and the administrative bureaucracy is a major one. One example is the requirement that a disproportionate amount, up to four times the standard reimbursement payment, be made to those hospitals which have a disproportionate share of Medicaid patients. As a result, Medicaid payments to such hospitals are more profitable than any other source of reimbursement, including private insurance. Estimates of the projected costs of Medicaid soar to $360 billion in year 2000, which is more than three times the current rate of expenditure in 1992.[8] Can we afford to continue this program without reform? We believe not and propose a system where the control of expenditures is transferred from the government to the recipients. This could be accomplished by issuing vouchers earmarked for medical care to poor families. Alternatively, but probably less effective, the states, which are responsible for administration of Medicaid, could subsidize health insurance premiums or monthly HMO subscriber payments.

Patient's Rights and Physician's Rights

Removal of the patient as an economic entity has allowed

government to usurp patients' rights: The right to make with physician input their own choices.

When power is transferred to a centralized authority, the physician, as well as the patient, acquires a different master and the welfare of the system takes precedence. Until recently, a patient covered by Medicare had no right to make an agreement with a physician outside of Medicare if the government had not approved that type of transaction. For example, a Medicare patient seeks treatment from a physician who deliberately does not treat Medicare patients, but as a personal favor the physician accepts the patient for treatment. The patient fully intends to reimburse the physician handsomely. Such private action had been held by Medicare, Part B, to be illegal but legal review resulted in an October 26, 1992, court ruling that substantiated private contracts. A physician who accepts payment from such a patient has been subject to prosecution, a $2,000 fine for each claim, plus twice the amount of "excess" charges, whether or not the action is purposeful or inadvertent.[9] Furthermore, a provider, practitioner, or supplier who routinely waves co-payment or deductibles could also be criminally prosecuted.[10]

In 1991 the Supreme Court upheld the U.S. Department of Health and Human Services regulations that prohibited recipients of Title X family-planning funds from discussing the option of abortion with pregnant patients, even if the patient requested the information.[11] Thus the court imposed direct restraints on the doctor-patient relationship by prohibiting the discussion of abortion and requiring that each patient be referred for prenatal

care. The fact that President Clinton recently restored these rights does not negate the fact that a precedent has occurred.

The population currently senses an imbalance toward more government controls. The proposed Clinton Administration plan relies on Health Maintenance Organization (HMO) gatekeepers (primary care physicians and registered nurses), to limit the patient's access to specialist care, and thus to high-tech, high-cost tests and surgery. Already a Public Health Service guideline is questioning the right of Medicare patients to choose cataract removal with lens implant surgery over thicker eyeglasses and magnifying lenses. The total surgical bill to Medicare is nearly $4 billion annually for 1.5 million of these operations.[12] This is a cost-effective procedure: a one-hour or so outpatient surgi-center visit replacing the earlier week-long hospital stay. But as news of this miracle of good vision spreads and the numbers of elderly increase, the total bill for this high-benefit procedure will soar. Thus the new Public Health Service guideline.

As federal funding of medical care increases, so will opportunities for restrictions on medical care delivery.

PROPOSAL

Independent Medical Care Accounts

We propose that each individual be given the right to establish an Individual Tax-Free Medical Care Account. The basic

structure was conceived in the 1970s by the late Dr. F. Michael Smith from Thibodaux, Louisiana. His plan was formally adopted by the Louisiana State Medical Society on March 12, 1982, as Resolution #34 "Payment of Medical Expenses from IRA's." Interest in this concept has accelerated over the past few years.

A coauthor (RRC) of this paper was instrumental in Singapore's 1984 adoption of a similar "Medisave" program under its Central Provident Fund's forced savings umbrella by individuals to be used initially only for hospital expenses. In 1992 Medisave's withdrawal limit for doctor's daily attendance was S.$50 (Singapore dollars) and for surgery at seven levels of complexity from S.$150 to S.$5000. This is financed by six to eight percent (graded by age) of salary with an overall maximum on individual fund size.[13]

United States citizens do not yet have the right to use excess funds in existing Individual Retirement Accounts (IRAs) for catastrophic medical expense, or to establish medical IRAs subject to a similar tax structure. Nor can the relatively few over-funded company pension funds reallocate the end use of their savings to health care.

The current tax law states that premiums for health insurance paid by an employer for employees are expenses and as such are tax deductible, but not if paid by the employee. The tax law should be changed to transfer that deductibility to individuals who establish IRAs earmarked for their health expenses. This action would increase revenues from the corporate income tax. Employers could then offer three choices to employees: private insurance, a

prepaid plan, or the money could be deposited in an independent tax-free account controlled entirely by the employee. The employee could decide the level of out-of-pocket expenses he/she could afford each year and buy a policy with that deductible. The government could cap the tax-free portion of annual premiums allowed. Any remaining money in the account would acquire interest. This differs from the current cafeteria plans where any unspent, pre-tax money is lost to the employee, savings do not accumulate, and the insurance is not portable if they become unemployed or change jobs. Simultaneously, the employer would lose on a gradually phased-out basis over several years the now unlimited deductibility for payments of health insurance premiums. To compensate, employers would reduce the level of health insurance premiums that they would pay to equal the government established cap for corporate income tax purposes. Demand for medical care would be contained and real wages would rise. Employees would have portable tax-free medical IRAs with the responsibility to pay for their own medical care and would spend their own money more carefully. This may not be considered a politically viable approach and apparently it has been discarded by the Clinton Administration. It is a necessary step that corrects the error of the early 1940s that has made U.S. health insurance coverage directly dependent on employment. This policy diverted earned income away from money wages to tax free health insurance premiums and ballooned the demand for medical care out of proportion to the demand for other goods and services, many of which are also necessities. If, when wage rates were frozen

during World War II, employers had offered fringe benefits involving another sector of the economy than payment of health insurance premiums, the impending disaster thus created might have been recognized sooner. For example, tuition reimbursement to public and private colleges would have worsened the explosion of college costs which we are now experiencing. Supply responds to demand. Health care is the fastest growing sector of the economy. Government, by imposing ceilings on money wages and its manipulation of government's corporate income tax rules, fostered today's dilemma.

Individuals need protection against catastrophic medical costs. Such coverage is available in the private market, but it must be purchased with after-tax money. In April 1993, Blue Shield of California marketed through newspaper fliers policies with individual deductibles of $1,000 and $2,000. The monthly premium rates for single males, ages 30-39, was $70 with a $1,000 annual deductible and $55 for a $2,000 deductible. The cost of a $3,000 deductible policy offered by Blue Cross of Idaho for a 40-year-old man, wife, and two children is less than $1,000 per year (approximately $81.45 per month).[14] If the tax law were changed, individual medical care accounts would become more attractive to families.

The Uninsured

There are 35 millions without <u>any</u> health insurance coverage including Medicare or Medicaid. It is a common misconception to believe that all those without health insurance are not working,

are poor and remain poor most of their adult lives. Many college students have no health insurance coverage and little or no income. But these individuals do not remain poor. In fact, over a ten-year period, the majority of individuals with incomes in the bottom quintile move upward at least two quintiles.[15]

On the other hand, about 30 percent of the uninsured have incomes below poverty level. These are mostly men who, unlike mothers and children, are not targeted by Medicaid. About 20 percent of the uninsured have incomes three or more times the poverty level.[4] About 54 percent of the uninsured work a full year of 35 or more hours per week.[16] Many of these work for small firms that perceive themselves to be priced out of the market. Many young, healthy men and women believe that the price of health insurance premiums is too high for their limited incomes and their self-assessed low risk of needing medical care. Portable, limited medical IRAs should appeal to them.

We propose that the poor be given the same rights afforded other citizens. This means that the government would no longer pay their medical care costs directly. This could be accomplished if vouchers earmarked for medical care were issued to the poor. The State of New York already uses a computer software program to identify those local districts where it would be cost effective to buy health insurance coverage in the private market for its Medicaid enrollees. Alternatively, the money now spent by government for the poor could be used to establish independent medical care accounts. There are about 32 million persons below the poverty level and of these about 7 million are single

individuals. The 25 million in families form roughly 9.5 million family units which at $4,000 a unit would cost $38 billion. The 7 million singles at $2,000 each would cost $14 billion for a total of $52 billion. Obviously, more people could be classified as poor, and politically 110 percent of the arbitrarily chosen poverty level may be a more appropriate cut-off point.[17] The approach given here leaves $67 billion to meet the heavy long-term nursing-home care bill paid by Medicaid.

The average low-income individual, although poor, is capable of making rational decisions concerning his or her own medical care. The argument promoted by opponents of cash vouchers earmarked for medical care is that authoritarian controls work best. The belief is that Medicaid and other bureaucratic programs with a sea of rules over coverage, reimbursement, and prior authorizations is the most judicious way to benefit the patient. This is elitism at its worst, a belief that only a chosen few have the ability and the knowledge to find answers to the problems of the poor; that others who have little or no knowledge of their personal value systems know what is best for them.

Political Realities

The gulf between the theoretical and the practical, between knowing answers and implementing solutions, is daunting. Political reality dictates that any comprehensive plan capable of changing the system of medical care will meet almost certain defeat because it will arouse each of the special interest groups. In the recent past, a slowly growing, almost unnoticed, resurgence

of interest in methods of activating market forces in medicine has developed. Increasing attention has focused on independent medical care accounts: On June 4, 1992, Bob Michel (R. Ill.) with 74 cosponsors filed a bill, H.R. 5325, titled "Action Now, Health Care Reform Act of 1992," which included these accounts. On June 18, 1992, Senator John Breaux (D. La.) with five cosponsors filed a bill, S. 2873, titled "Medical Cost Containment Act of 1992," where medical care accounts was the central issue. The Secretary of the Treasury, Lloyd Bentsen, recently supported independent medical IRAs, and a host of new bills are expected now that the Clinton Administration has released theirs.[18]

Trial balloon policy formulation of benefits apart from a parallel consideration of tax revenues has raised the expectations of voters that they might get more and at little cost. The Clinton proposal continues that fantasy.

The real battle is not over quality of care, access to care, what medical benefits to fund or what taxes to impose. These are side issues, red herrings. The real battle is over individual rights and philosophy. The choice is ours to make. Furthermore, if we have the gumption to meet the challenge, we will set a course for the developed world as well. We will demonstrate the reasons why we are the only country in the world that still has a decentralized system of medical care, that it is not this country which is out-of-step with reality. Consumer sovereignty and consumer power through the market system will work in all sectors of a free economy.

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