Inside Highlights

The Medical Conundrum

"Suppose you had grocery insurance. With [insurance] paying 80 percent of the bill, you would fill your cart with lobster and filet mignon. Everything would cost more because demand would rise and supermarkets would stop running sales. Why should they—when their customers barely care about the price?"

--John Stossel, journalist, author, Give Me a Break

Tax and Financial Strategies

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Wealth Creation Strategies

Medical Socialism: A Thousand Little Battles

"The whole science of economics…is how do you satisfy unlimited demand with limited resources?"
--Peter Schiff, President, Euro-Pacific Capital

"If you think health care is expensive now, wait until you see what it costs you when it's free."
--P.J. O'Rourke, American humorist

A decade and a half ago in an article entitled "Medical Socialism 2000" published in two medical magazines I lambasted the idea of a governmental takeover of health care. So far, we have escaped the system that brought East Germans the Trabant, the socialist-built car for which East Germans put themselves on decade-long waiting lists to purchase (and then quickly trashed when freer markets offered them alternatives). Medical care has been subjected to a muddled half-way-house mess ever since.

I was tempted to send you my still timely 1992 piece in lieu of writing this update (a hard copy of the original article is available on request). It's amazing so little has changed. Let's revisit the subject by starting with a few simple questions:

1. Do we really want the equivalent of the IRS—with paperwork foul-ups that are far worse than any you might imagine—to exercise control over health care?
2. Do we really want health care to be run like the Transportation Security Agency and by people with their lack of compassion?
3. Should we trust the same system that has the greatest spy agencies on the planet to wield even more control over health care? Remember, these are the same people who believed an alcoholic, code-named "Curveball," who told authorities that Saddam Hussein had weapons of mass destruction. Should we really give a government that got us into a war based on a lie it should have detected more control?
4. How would costs drop when Washington, D.C.—which voters think wastes 40% of all tax dollars—completely controls health care?
5. How could we spend less when everyone is "insured"—which, by design, increases demand for medical care—recalling from Econ 101 that an increase in demand increases overall costs?

Government has so completely distorted the pricing and delivery of medical care it's almost impossible for non-economists to understand that the problem *is* government. Demagogic pandering to emotions and outright lies about our care vs. that in other nations have become so prevalent, it's difficult to grasp that the solution is in free markets. I'll try and explain, jumbled though it may be. Along the way, you'll find that if we are to avoid thousands of little battles, we need to take the politics out of medical care rather than increase the scope and power of politics over such care.

Private providers can be incompetent. Government ones are worse.

Private companies are by no means perfect. Dishonest and incompetent employees have ruined my day on a number of occasions. A Club Med vacation turned into the worst trip of my life. (I haven't done Club Med since.) I've been cheated by computer service providers and banks. I've purchased things that didn't work and dined out on meals that made me ill.

However, nothing matches the imperfections of government, where dishonesty and incompetence are institutionalized because we can't withhold funds and take our business elsewhere.

An IRS auditor once threatened to report me to the Director of Practice, who oversees Enrolled Agents. A negative report could have destroyed my livelihood. After cooling down for a day, I called his supervisor and calmly explained the situation. She quickly understood that my position was completely reasonable and told me she would assign a different auditor and instruct him to issue a "no change" report, meaning my client would get every deduction claimed. I asked

whether I could write a letter to her manager commending her and condemning the auditor and she told me "Sure," but added, "Do you know what it takes to get someone around here fired?"

This is a clue to one of the key problems of government: it can be next to impossible to get rid of bad apples. Since non-performing and destructive employees in private companies can take down the entire organization, they're usually quickly terminated. In government organizations, employees are "transferred."

However, challenges in dealing with incompetent employees are only the beginning of problems in governmental organizations.

When government is involved we fight over prices, service and capital allocation. That's uncivil.

Consider the fact that we don't fight or argue over which computer to buy; you buy yours, I buy mine. We'd never argue over which food market, or clothing store, or car dealer to buy from. You make your choice; I make mine. I don't tell you which movie to see; you go to the one that appeals to you, not to me. It's civilized when we make our own choices.

But we fight over government and all that it provides. We argue over how much to tax and spend on schools, what to teach and how to administer. We battle over how many roads to build and widen. Despite the fact that people die because of bridge and levee failures, we fight over funding for maintenance. We don't have these struggles under private ownership—the owners of Disneyland don't argue over or unnecessarily delay the repair of roller coasters or potholes on Main Street. Compare this with a system of majority rule and government ownership or control, where we not only battle over thousands of such details, but over which it's difficult to even have a civilized discussion. When you think about the arguments that result, using the power and force of government to make decisions rather than freedom of choice is uncivilized.

Government can't do as good a job of allocating scarce medical resources as private providers.

Other people spend your money to achieve their ends, not yours. You spend your money on things you want. By definition, in the aggregate you do a better job of allocating your scarce resources, medical and otherwise, than government could ever do.

Where politics controls resources, innovation suffers. When creative innovators have anyone—especially government bureaucrats—looking over their shoulders, they go to other industries or countries to create. The medical technology behind in-vitro fertilization (IVF) would barely exist were it not for a Congressional accident in 1974 that prevented the government from either funding or regulating IVF research, thereby allowing private, competing, unregulated clinics to meet consumer demand with innovations. Almost no innovation occurred in Europe, where assisted reproduction was subject to strict government oversight. As P.J. O'Rourke puts it, "Government controlled health care [drives] the best people out of the business. Who wants to spend years studying to be a doctor, just to become a government bureaucratic hack?"

Private misallocations of resources occur, but are quickly corrected by market forces. Government misallocations are rarely corrected. While Staphylococcus kills 19,000 Americans yearly, anthrax has killed five in all years (and only because of one home-grown alcoholic scientist, Bruce Ivins), yet we spend $50 billion on total civilian biodefense and a relative pittance on staph infection research. Obviously, biodefense has a more powerful lobby than infectious disease researchers. Recently, government forced us to make gasoline out of food, resulting in skyrocketing corn prices. Corn producers have so far blocked any changes to the regulations that created this mess even though by now everyone knows it was a failure. If we ask the question, "Who is government trying to please—consumers or politically powerful constituents?" the answer is always the latter. And righting such misallocations not only takes ridiculous amounts of time, but also triggers political battles that can divide the country. Politics is an uncivilized way of solving problems.

Private providers are far more flexible, which enhances innovation.

One of the keys to innovation is flexibility. Private companies can move and flex and change as circumstances require. Governmental entities are rigid and change at a glacial rate, if at all. As Randall O'Toole wrote in a Cato Institute report, *Cato's Letter*, "Private plans are flexible and we happily change them when new information arises. In contrast, as soon as a government plan is written, people who benefit from the plan form special interest groups to ensure that the plan does not change, no matter how costly it proves to be to society as a whole."

Private companies don't need 50% of the vote to change a way of doing things. They don't need 50%+ to say, "Let's produce movie X or make product Y." A tiny fraction of 1% of consumers demand something and private providers produce or change it.

The inflexibility inherent in government systems stifles styles of care and innovative ways to save money. For example, while there are some 7,500 specific tasks for which Medicare reimburses, telephone and email consultations are not among them (which is also true for insurers, who generally follow Medicare's rules and pricing policies). A failure to keep up with technology is par for command-and-control bureaucracies.

One walk-in clinic was almost shut down by the West Virginia insurance commissioner over an innovation in pricing that saved medical consumers

gobs of money. For a monthly fee of $83 per individual or $125 for a family, Dr. Vic Wood's clinic provided unlimited primary and urgent care. One local business owner switched to a major medical plan with a high deductible and used Dr. Wood's clinic for nearly all primary care and shaved almost 40% off his company's health care bill. Wood's competition—insurers—tried to get government regulators to shut him down. He survived only after taking his battle to offer such care to the state legislature. One of the problems with political decisions vs. private ones is while we may win a battle we could just as easily lose it, and there are theoretically thousands of such battles under a system of government regulation that must be waged. Rational entrepreneurs are far less likely to take chances innovating new and improved equipment, drugs or pricing schemes when their survival depends on a favorable decision from a politician or bureaucrat. As a result, the more government is involved in an industry, the lower the rate of innovation. Is this what we really want to govern the future of our health care?

Someone else paying the tab—not increases in technology—increase overall costs for everyone.

Tax policy encourages third-party payments for every little procedure. Where third-party payments are *not* the norm, including cosmetic and LASIK surgery, optometry and dentistry—where most consumers pay their own bills—a vibrant, creative and entrepreneurial market exists. While increasing use of technology is blamed for ever-higher prices in medicine, tremendous technological improvements in cosmetic surgery over the last 15 years have occurred side-by-side with a decline in inflation-adjusted prices and a six-fold increase in the number of procedures. The real price of LASIK surgery has plummeted by 30% over the past decade. You can even get a fixed or package price on such surgeries, which is almost impossible in conventional government-controlled medical markets.

Governmental pricing schemes unnecessarily increase costs, stifle innovation and reduce the quality of care.

A ludicrous example of inane inflexible pricing in the government market, Medicare, results from fee schedules established in the 1980s and mostly just updated for inflation. The schedules weren't based on competitively determined prices, and even if they were wouldn't be applicable even a few years later with fast-moving technological innovations, much less two decades later. One outrageous example is an oxygen concentrator, a device that delivers oxygen through a tube to patients, that costs about $600 on the open market. Either because the price was far higher or because a Soviet-style bureaucrat mispriced it back in the '80s, Medicare pays beneficiaries to rent the machine for a rental period set by statute, 36 months. The monthly rental payment, also set by statute, is $198, which nets the oxygen concentrator rental company a tidy $5,714, or almost ten times what it now costs to purchase the device. Lobbyists for the crony capitalist oxygen concentrator providers are doing what they can to block changes to the payment and rental schedules.

Such schemes suppress creativity in improving care. Geisinger Health System in Pennsylvania offers a 90-day warrantee on heart surgery. If a patient has complications during that period, Geisinger takes care of it without billing either the patient or insurer. Obviously, they charge a bit extra to cover the occasional problem. But Medicare doesn't discriminate among styles and outcomes: each procedure is paid for, which results in providers getting paid more when patients have complications (there's a bill for every visit, test and readmission). The inflexibility of a government system prevents Medicare from paying a bit more upfront for the initial surgery even though it would save taxpayers overall. Another battle needs to be waged to solve a problem that private providers would solve in a heartbeat. When Duke Medical Center figured out a way to lower the cost of treating congestive heart failure by 40% and in the process increased survival rates, it lost nearly all the savings it created because Medicare didn't quickly adapt its compensation levels by allowing it to profit from its creativity. Instead of the entrepreneurial spirit finding ways to provide better care at lower prices, pseudo-capitalists find they can increase their recompense by finding ways to bill for more services. Perversely, medical innovators who lower costs and improve outcomes earn less than others. Is this the system you want to completely take over your health care?

Allowing the "rich" to initially buy high-tech gadgets that the less fortunate may not initially be able to afford allows everyone access to such gadgets in the long run. Now substitute "medicine" for "gadgets."

Private markets allow the rich to buy lobsters and Porsches, while the rest of us may eat chuck steak and drive Corollas (which, at least, is better than beans and Trabants). However, this freedom to produce and get rich has a tendency to raise all boats,* particularly where technology is involved.

Hardly anyone could afford to buy a plasma TV when they first arrived on the scene. However, as the rich increasingly demanded plasmas, competition and volume compelled manufacturers to gradually reduce their costs. Now, practically anyone can afford a plasma TV. The same is true for first generation computers, cell phones and countless other high tech gadgets. Can you imagine how little technology would have evolved if politicians of the egalitarian stripe controlled the marketplace for TVs and cell phones? They'd still be struggling to supply everyone with a 19-inch black and white and cell phones would be the stuff of science fiction.

Consider how this may apply to medical care, which is becoming evermore high-tech. If politicians and crony capitalists via politicians control the allocation of scarce medical resources, we may never get new, innovative and initially expensive equipment, drugs and treatments. While only the wealthy could afford cosmetic surgery three decades ago, far more people can afford it today. While only the wealthy—or a good, solid insurance company to which we may pay seemingly high premiums—can afford $100,000 cancer treatments, prices may eventually drop to affordable levels. They often do so in medical markets relatively free of government control. With government, unless politically powerful constituents fight for it in another one of thousands of uncivilized battles, we may never get that opportunity.

The 47 million "uninsured" are mostly insured. The problem of high costs results from insuring for the medical equivalent of oil changes.

Out of that much-vaunted figure—which includes everyone uninsured during the year for even one day—roughly 10 million are not American citizens. Over 18 million have an annual household income of more than $50,000, which puts them in the top half of income levels, many of whom could afford high-deductible catastrophic coverage. Millions are eligible for Medicaid but have not applied. Since they can apply and receive coverage instantly, they are for practical purposes covered. And many millions more have chosen not to purchase insurance because they are young and healthy or are uninsured only for brief periods because they are between jobs.

Lower the cost and people will be more likely to purchase coverage. You have a choice: lower costs through competition and deregulation or do so via government mandate. Because the latter, in the absence of increased supply, may result in months-long lines to get in the door, make your choice carefully.

Insuring everyone, especially from first dollar of expenditure, increases demand. Just like with everything else, an increase in demand—unless supply is ramped up, which in a bid to contain costs won't happen—results in higher prices. Can you imagine what the price of a Mercedes would be if everyone was guaranteed one? Actually, you can't, because they'd be rationed—you'd be standing in line for a hundred years.

Costs are high partly because of a potpourri of other government regulations.

Such regulations are a large part of the reason it takes an average of 13 years and $800 million before a new drug reaches your local pharmacy. Government restricts the number of physicians by limiting the number of medical schools, thereby limiting the number of doctors. A lower supply of anything—including doctors—inevitably leads to higher prices.

Insurers are restricted by regulation in many states from charging lower rates for healthier lifestyles, despite the fact that many chronic diseases, including heart disease, diabetes and many cancers can be prevented, better controlled or delayed by making better choices. This not only increases the cost of medical care for everyone, but harms those who might otherwise be driven to make such healthy changes if their bottom lines were affected.

High prices are not a result of insurers' administrative costs.

Such costs actually save money overall. Companies evaluate and process claims and weed out fraud. If Medicare was as careful as private industry, they might save money too. A Miami investigation discovered that over one-third of 1,600 businesses billing Medicare for services didn't even exist. Monitoring costs money and private industry, lambasted for doing so and spending necessary funds on it, is just as much a target of fraud as is Medicare.

The dramatic reduction in the number of emergency rooms over the last decade resulted primarily from one government regulation.

In a classic case of the law of unintended consequences hospitals since the mid '90s have been forced to treat all comers for emergency care. Rather than government imposing a requirement and figuring out a way to fund it, the law simply required hospitals to treat—no payment required. In other times, those forced to work for others without compensation might be considered "slaves" or the system one of "conscription," but since the purpose was to help the destitute, no such honest appraisal has been forthcoming. If society through its government feels compelled to impose such requirements, the cost should be borne by all, not just be a select few. The consequence of the failure to collect for services rendered on a far greater scale than before has been a dramatic reduction in the number of emergency rooms that remain open. The more cynical among us might wonder if the consequence of this unfunded requirement was intended as a ploy to insure the failure of private hospitals, giving government an excuse to eventually take over.

The U.S. spends much more than other countries with national (socialist) health systems largely because we can afford it and have, so far, refused to stand in line for care.

In subsistence economies, limited resources are focused on providing food, shelter and clothing. As these needs are met—as wealth increases—people willingly devote more to less fundamental needs such as pollution reduction and medical care. All of these are goods for which we can afford to devote greater resources only as income increases. Per capita income of U.S. residents is 20-40% higher than almost all other Western European nations and Japan. One study found that health spending increases by $230 when per capita income increases from $30,000 to

$31,000 and by $500 when per capita income increases from $40,000 to $41,000. Of course we spend more per capita than other countries—we can afford it.

But there are other, more perverse reasons for seemingly lower costs in other countries, including lower pay for medical practitioners and, as mentioned previously, queuing. Doctors recently protested low pay in Germany and their pay is capped in Canada. The average French doctor earns $55,000 yearly, compared with $146,000 for primary care physicians in the U.S. and $271,000 for specialists. Doctors and hospitals must accept a set of fixed prices for services. Roughly 2% of New Zealanders, Canadians and Brits are on waiting lists to get into a hospital at some point during the year every year. These are not just people who need surgery—they comprise percentages of the entire population of those countries. Last year, more than 43,000 patients had to wait outside in ambulances for at least an hour before they could be seen in Britain's National Health Service emergency rooms. As journalist John Stossel puts it, the only Canadian patients that consistently have immediate access to cutting edge technologies such as CT scans are those furry creatures that bark and meow. Remember the rigidity of Medicare? Foreign countries don't limit such rigidity to only the elderly. Is this the system we want for our country?

In Canada and Britain, the rate of coronary bypass surgery is one-third to one-fifth that of the U.S. Aside from the fact that many such surgeries might be avoided with proper diet and lifestyle changes, the savings by avoiding this one very expensive surgery could account for a large part of the lower medical costs borne by other countries. Capital equipment and innovation are expensive as well. Adjusted for population the U.S. has five times as many CT scanners and four times as many MRI scanners as the U.K., Canada and France. The U.S., with 5% of the world's population develops 50% of all major medicines, has produced 18 of the last 25 winners of the Nobel Prize in Medicine and invents more high tech medical instruments and technology than anywhere else. The rest of the world is being subsidized by the U.S., which increases our costs vs. theirs.

Many countries simply withhold surgery and treatment based on age. New Zealand, for example, withholds kidney dialysis for anyone over 75. Such decisions should be made by insurers and consumers in a competitive marketplace, not by high-handed government bureaucrats with a one-size-fits-all mentality.

The World Health Organization (WHO) study, which placed the U.S. 37th in the world for health care, is a classic in the annals of political propaganda.

The WHO study is full of holes. It bases its rankings on political criteria, including "fairness," "tobacco control," how progressive the tax system of a country is and a failure to provide all citizens with health insurance, regardless of quality. The specific rankings within the study are far more favorable to the U.S. It ranks the U.S. number one in the world in responsiveness to patients' needs in choice, autonomy, timeliness of care and confidentiality. It penalizes the U.S. for lower life expectancy, without consideration for levels of obesity, homicides and accidents. Correcting for just the latter two items, the U.S. rises to the top for life expectancy (we have far more cars and, hence, fatal accidents than anywhere else). In other words, we have longer natural life-spans despite the fact that in the aggregate we are more obese than practically anywhere else. In one of the most classic cases ever of lying with statistics to achieve political ends and propagandize, the U.S. is penalized for high infant mortality. The WHO study fails to account for the fact that very low birth-weight infants have a much higher probability of surviving birth in the U.S., which raises our infant mortality rate. These high-risk infants aren't even included in the mortality calculations in many other countries, including Western ones. Cuba's much-vaunted low infant mortality results from the fact that problem pregnancies are rarely brought to term because the government "encourages" aborting babies with serious apparent health problems and, incredibly, doesn't include infants who die during the first day of life as having been born.

U.S. cancer survival rates are the highest in the world. Roughly 65% of cancer patients survive five years or more in the U.S., while the figure in Britain is less than 50%. Of those diagnosed with colon cancer, only 30% in the U.S. die from it, compared to 74% in Britain, 57% in Germany and 36% in Canada (perhaps approaching the U.S. figure because so many Canadians cross the border for medical care). While less than 25% of U.S. women die from breast cancer after diagnosis, comparable figures in Britain, France and New Zealand are 46%, 35% and 46% respectively. The five-year survival rate for prostate cancer, an extremely treatable disease, is 98% in the U.S. and a pathetic 77% in the U.K. Medical care in the U.K., as in other nations with medical socialism, is replete with stories of waiting for a diagnosis and then for treatment months after a diagnosis. In Britain, 13% of patients who need radiation never even get it due to equipment and staff shortages. Roughly 40% of cancer patients in Britain never see an oncologist. Delays in getting treatment for colon cancer result in nearly 20% of such cases that were considered treatable when first diagnosed to be incurable by the time treatment becomes available. The British National Health Service recently announced its goal to insure that patients do not have to wait more than 18 weeks between the time a general practitioner refers them to a specialist and beginning treatment. Can you imagine the thousands of little battles that go on in other countries that we never hear about? Do we really want that for the U.S.?

So what do we do?

Choice, competition and responsibility need to be maximized. Here are a few

ideas.

1. Tell everyone "you have to buy insurance now or you might be stuck without it later." In other words, it's time to take responsibility for your own health care. If we need to offer refundable tax credits to encourage this, so be it. At the same time, put an end to rules requiring "guaranteed issue," which requires insurers to offer coverage even after someone has become sick—the equivalent of requiring an auto insurer to offer coverage after an accident.

2. Just as we tend to eat more at buffets because refills are free, many are inclined to use more health care because the costs ("premiums" or "taxes") are paid up front and often by someone else. Costs, therefore, need to be shifted away from premiums and into co-pays and deductibles. Tax policy can be changed to encourage people to shop for the best price and service as well as restrain overuse of scarce medical resources by allowing deductions for policies with high deductibles and co-pays along the lines of Health Savings Accounts. As John Stossel points out, "insurance is a terrible way to pay for things." If your car insurance covered oil changes and fuel, you wouldn't care how much gas you used or what it would cost. You and your service station would be burdened by paperwork, the system would invite cheating, incentives would be distorted and prices would skyrocket.

3. De-regulate medical care in a way that increases flexibility, innovation and competition among providers. If we think outside the box, the possibilities in this category are practically endless, but we could start by addressing the problems brought up in this article. Just like consumer power works in cosmetic and LASIK surgery, it will work in other areas of medicine.

4. In Florida, general surgeons pay $175,000 annually for liability coverage and ob-gyns pay more than $200,000. Create a "loser pays" system, in which those bringing frivolous lawsuits not only lose their case but must pay the other party's costs. In addition, cap non-economic damages.

5. Create a clearinghouse for information about doctors and other providers, including all the negatives. Putnam General Hospital in West Virginia almost closed because it recruited an orthopedic surgeon named Dr. John King to relieve a crushing caseload. The hospital followed standard procedures to verify that King was licensed and to confirm King's previous employment. Reference checks gave it no cause for concern about hiring Dr. King. Unfortunately, several months after his arrival the hospital identified "problems" (my guess: "alcoholism") and revoked his surgical privileges. Because Putnam General had deep pockets, lawsuits were quickly filed on behalf of 100 plaintiffs and Putnam almost closed. It turns out, had Putnam received accurate and complete information about Dr. King's previous practice, they never would have hired him. Unfortunately, hospitals can't share information on doctors' illegal or unethical behavior with each other for fear of being sued by those doctors. Anyone who knows the sordid history of Martin Luther King hospital in Los Angeles is aware that this is not an isolated incident. We need a complete and open flow of information about all medical practitioners if we are to avoid such lawsuits (100 suits for one doctor!) and reduce the costs of litigation, which winds its way into all of our pocketbooks. If Kanye West's mother knew about surgeon Jan Adams' DUIs, she might be alive today.

6. Alcoholism and other-drug addiction by many estimates account for 25% of all medical costs and 50-90% of emergency room admissions. The following may seem radical, but those who understand addiction will appreciate the idea. Everyone admitted to ER should be tested for levels of alcohol and other drugs in the system (incredibly, this is not currently done) and, if that is the likely reason for being admitted, a promise must be made: treatment one last time for any problem relating to addiction at the public's expense. Allow insurers to opt into this sort of approach as well. Addicts usually get clean and sober only when they see that promises to enforce a boundary will be kept. Decreasing the number of active addicts would dramatically reduce overall medical costs. As a side benefit, this might also decrease the numbers of broken homes, dysfunctional families, criminal and unethical behaviors and other tragedy.

7. We need to accept and embrace the idea that limited resources cannot meet unlimited demand. There are only two ways to limit demand: the price mechanism and government edict. If we choose edict, we will succumb to queues, decreased capital spending, less innovation, rigidity of care and services and lower quality of care. If we choose prices, we will continue to have the most advanced health care on the planet. While we may suffer the occasional inequity, these will likely be alleviated by caring and concerned individuals via charity and a more rational tax policy. The alternatives are choice, competition and responsibility—or bureaucracy.

* John F. Kennedy employed the expression "raise all boats" to combat criticisms that his massive tax cut would benefit mostly wealthy individuals.

Doug,

Your last issue of *Wealth Creation Strategies* was terrific. I would like to have my kids read your piece on "The Wealth of Individuals: Part 1." Do you have an electronic copy? If not, I would like to photocopy and send it to them.

Bob

Dear Bob,

Thanks so much for the accolade, Bob. That's largely who I intended it for--young adults, even if the more mature among us might benefit as well. Sure, go ahead and copy the whole issue--or simply go to www.dougthorburn.com where we've archived all issues since 2002!

Doug

PS: You'll see "The Wealth of Individuals: Part 2" in the *next* issue.