

The Fallacy of Government Sponsored Single-Payer Health Care

A consumer-driven model proves best for both patients and providers.

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Almost everyone agrees that America's health care system is terminally ill. It is the most expensive in the world, with the US spending more on health care per person than any other industrialized nation. Recent estimates put health care spending at around 16% of U.S. GDP. In 2007, the U.S. spent \$2.26 trillion on health care, or \$7,439 per person. 46 million people are without medical insurance. The health care share of GDP is expected to continue upward, reaching 19.5 percent of GDP by 2017.¹

What most do not agree upon is how to solve the problem associated with rising health care costs. One argument is that single-payer universal health care is the answer. By paying out of one fund the advantages is administrative simplicity. Others think that the mandatory private purchase of health insurance by all is the answer, as is done in Massachusetts. A third option is that we need to adopt the system offered in Canada., where some see the free market and consumer-driven care as the solution. While all proposals are well meaning, the law of unintended consequences spoils the capability of centrally controlled health care schemes. We will take aim at the history of rising health care costs, the Canadian model, the laws of unintended consequences and examine our options going forward.

History of Health Insurance

The first U.S. President to propose a prepaid health insurance plan was Harry S. Truman. On November 19, 1945, in a special message to Congress, President Truman outlined a comprehensive, prepaid medical insurance plan through the Social Security system.²

Before the advent of health insurance, patients were expected to pay all health care costs out of their own pockets, under what is known as the “fee for service” business model. The fee for service business model was relatively inexpensive and reliable, with doctors even making house calls. But it was not without its problems. Medical conditions such as infection, pneumonia, influenza, and tuberculosis were the leading cause of death and advances in medical products and services were limited. Serious innovation was still years ahead. My father recently told me that his birth in 1943 cost a grand total of \$35; that’s \$438 in inflation adjusted terms. And births at that time mandated the mother and child to spend several nights in the hospital, as compared to today’s same-day delivery.

Nonetheless, for decades the U.S. healthcare system was the envy of the entire world. Not coincidentally, there was far less government involvement in medicine during this time. America had the finest doctors and hospitals, patients enjoyed high-quality, affordable medical care, and thousands of private charities provided health services for the poor. Doctors focused on treating patients, without the red tape and threat of lawsuits that

¹ "National Health Expenditure Data: NHE Fact Sheet", http://www.cms.hhs.gov/NationalHealthExpendData/25_NHE_Fact_Sheet.asp

² “eMaxHealth: The History of Medicare”, <http://www.emaxhealth.com/72/1272.html>

plague the profession today. As time when on, most Americans paid cash for basic services, and had insurance only for major illnesses and accidents. This meant both doctors and patients had an incentive to keep costs down, as the patient was directly responsible for payment, rather than an HMO or government program.

The Advent of Medicare and Medicaid

The 1960s however saw a plethora of concrete moves by the federal government to consolidate and modernize the U.S. healthcare system. With Lyndon Johnson's Great Society initiative, the U.S. established public health insurance for both senior citizens and the underprivileged. Known as Medicare and Medicaid, these two healthcare programs granted certain groups of Americans access to adequate healthcare services.

In 1965, the Social Security Act authorized Medicare and provided federal funding for many of the medical costs of older Americans. This was the first foray in socialized medicine, by making its benefits available to everyone over sixty-five, regardless of need, and by linking payments to the existing private insurance system.

Also a product of Johnson's Great Society, Medicaid was created in 1965 via Title XIX of the Social Security Act. In 1966 welfare recipients of all ages received medical care through Medicaid and each state administered its own Medicaid program.³

Problems quickly surfaced with the Federally-sponsored Medicare and Medicaid programs that led to predictable results. Because Congress placed no restrictions on medical benefits and removed all sense of cost-consciousness, health-care use and medical costs skyrocketed. The medical providers quickly discovered they could charge more because the insurance would pick up the tab. Congressional testimony reveals that between 1965 and 1971, physician fees increased 7 percent and hospital charges jumped 13 percent, while the Consumer Price Index rose only 5.3 percent. The nation's health-care bill, which was only \$39 billion in 1965, increased to \$75 billion in 1971.⁴

The Health Maintenance Organization Act of 1973

The story behind the creation of the HMOs is a classic illustration of how the unintended consequences of government policies provide a justification for further expansions of government power. During the early seventies, Congress embraced HMOs in order to address concerns about rapidly escalating health care costs for all Americans, not just the poor and the elderly.

Thus, the Nixon Administration, working with advocates of nationalized medicine, crafted legislation providing federal subsidies to HMOs, preempting state laws forbidding physicians to sign contracts to deny care to their patients, and mandating that health plans offer an HMO option in addition to traditional fee-for-service coverage. Federal subsidies, preemption of state law, and mandates on private business hardly sounds like

³ Ibid.

⁴ "Blame Congress for HMOs" Twila Brase, "Ideas on Liberty by the Foundation for Economic Education". February 2001, <http://www.cchconline.org/privacy/hmoart.php3>

the workings of the free market. Instead, HMOs are the result of the same Nixon-era corporatist, Big Government mindset that produced wage-and-price controls.⁵

On December 29, 1973, President Nixon signed the Health Maintenance Organization Act of 1973 into law, creating the first mainstream mechanism for managed health care in America.

The law mandated that large employers offer their workers the option of signing up with an HMO instead of a conventional insurance company in their employee benefits packages. In this way, companies would prepay a flat fee to an HMO for all medical coverage that an employee might need, instead of taking out an insurance policy that would reimburse the employee for any medical expenses incurred.

To bring the privately insured into HMOs, Congress forced employers with 25 or more employees to offer HMOs as an option. Congress then provided a total of \$375 million in federal subsidies to fund planning and start-up expenses, and to lower the cost of HMO premiums. This allowed HMOs to undercut the premium prices of their traditional indemnity insurance competitors and gain significant market share.

By undercutting the competition, the tax code allows businesses – but not individuals – to deduct the cost of health insurance premiums, as defined in the 1974 ERISA law. The result is the illogical coupling of employment and health insurance, which often leaves the unemployed without needed catastrophic coverage.⁶

The combined strategy of government subsidies, federal power, and new legal requirements worked like a charm. Employees searching for the lowest priced comprehensive insurance policy flowed into HMOs, bringing their dollars with them. According to the Health Resources Services Administration (HRSA), the percentage of working Americans with private insurance enrolled in managed care rose from 29 percent in 1988 to over 50 percent in 1997. In 1999, 181.4 million people were enrolled in managed-care plans.⁷

Before long, employees began to expect health care benefits along with full-time employment. The stage had been set for third-party payment of health care bills, and consumers no longer cared how much their individual services had cost. Their health insurance company via their employer was now footing the bill. Also, by passing along the bill to the insurance companies, those in the pharmaceutical industry were also generating greater profits, as it was insurance companies footing the bill and not consumers directly.

⁵ Blame Congress for HMOs, Hon. Ron Paul of Texas in the House of Representatives. Tuesday, February 27, 2001. <http://www.house.gov/paul/congrec/congrec2001/cr022701.htm>

⁶ "Lowering the Cost of Health Care" by Ron Paul. <http://www.lewrockwell.com/paul/paul339.html>

⁷ Ibid.

Single Payer/Universal Health Care

Americans want to have the best medical care someone else's money can buy. And there are a number of tradeoffs to consider. Insurance is purchased to cover unforeseen events, yet the insured demand that routine physicals be covered. Employers want to offer insurance coverage to keep employees happy, yet need to keep their costs down. Insurance companies need to keep their costs down to remain competitive, yet have to pay increasing costs, so are constantly looking for new ways to cut claims. Physicians want to be paid what their services are worth, and need to cover increasing costs (new equipment, malpractice insurance, etc.) As the United States economy worsens, more companies will severely cut benefits, or drop them completely, adding more people to the rolls of the uninsured.

As a result of these challenges, groups in Washington D.C. and in Minnesota such as "Minnesota Universal Health Care Coalition" and "Minnesota Universal Health Care Coalition" are calling for a single-payer health insurance program, with the single-payer being the government. They feel the market is incapable of handling such challenges. Medicare, Medicaid, and TRICARE (United States Department of Defense Military Health System) are examples of single-payer health care. With that, come government price control, and the virtual elimination of consumer-driven free-market choice.

The United States National Health Insurance Act (Expanded and Improved Medicare for All Act, H.R. 676) is a bill submitted to the United States House of Representatives by Representative John Conyers Jr., D-MI. It establishes a universal single-payer health care system to provide for all individuals residing in the United States and U.S. territories. All medically necessary care is to be provided, such as primary care and prevention, prescription drugs, emergency care, and mental health services completely free of charge. In order to eliminate disparate treatment between richer and poorer Americans, the Act would also prohibit private insurers from covering any treatment or procedure already covered by the Act.⁸

Funding for the bill would be provided by (1) existing sources of government revenues for health care; (2) increasing personal income taxes on the top 5% income earners; (3) instituting a progressive excise tax on payroll and self-employment income; and (4) instituting a small tax on stock and bond transactions.⁹

Criticisms of the Single-Payer Model

Several criticisms have been leveled against the idea of a single-payer system. A single-payer system would put the government, rather than private insurance companies, in the role of deciding which procedures and medications would be covered. Alternative medicines such as acupuncture, chiropractic or massage therapy are usually not covered. In a single-payer system where hospitals and practitioners remain private, public money goes into private hands and therefore must be guarded to protect public trust. The bill

⁸ United States National Health Insurance Act. Wikipedia.
http://en.wikipedia.org/wiki/United_States_National_Health_Insurance_Act

⁹ THOMAS (Library of Congress). House of Representatives Bill 676.
http://thomas.loc.gov/home/gpoxmlc110/h676_ih.xml

prohibits a private health insurer from selling health insurance coverage that duplicates the benefits provided under the Medicare for All Act. The existing Medicare system is immensely complicated. The bureaucracy is burdensome and confusing at best. Converting to a single-payer system could be a radical change, creating administrative chaos.

While polling data indicate that U.S. citizens are concerned about health care costs and think the system needs reform most are generally satisfied with the quality of their own health care. According to a Joint Canada/United States Survey of Health in 2003, 86.9% of Americans reported being "satisfied" or "very satisfied" with their health care services, compared to 83.2% of Canadians. In the same study, 93.6% of Americans reported being "satisfied" or "very satisfied" with their physician services, compared to 91.5% of Canadians.

The Panacea of the Canadian Health Care System

The biggest problem today is about half the money goes to the health care middleman: management companies, drug companies, and insurance companies. In Canada, fees for doctors, hospitals and other providers are set by negotiations among doctors' associations, provincial or regional governments, and the national government.

Americans want the best coverage at the best price, but the Canadian system can be costly in several other ways. Wait times are notoriously slow for Canada's emergency rooms, major elective surgery, such as hip replacement, imaging procedures such as MRI, or specialized treatments, such as radiation for breast cancer.

The waiting list to get an MRI in Newfoundland can be two-and-a half years. In Thunder Bay, Ontario, it is 13 months. In contrast, a patient must wait only a few days in the United States. Equipment shortages are also a problem. In 1998 the U.S. had 16 MRI machines per million citizens, compared to 3.4 in the U.K. and 1.7 in Canada.¹⁰¹¹ Since 2002, the Canadian government has invested \$5.5 billion to address the problem.¹² But simply throwing more money at the problem is not likely to fix a system that is inherently broken. Young people are not allowed to opt out of the system, leaving them trapped in a system that will eventually collapse.

Another problem is that the Canadian Government is making health decisions instead of doctors and patients. Removing payment decisions from patients and doctors has severe consequences. Canada's socialized medical system, which designates knee replacement an elective, is sending patients scurrying across the border. Canadian national health care policy restricts heart transplants to anyone under age 55.

¹⁰ Peter J. Nelson. A Conversation about Canadian and American Health Care with Lee Kurisko, M.D. October 2008.

http://www.americanexperiment.org/uploaded/files/2008_publications/kurisko_oct_2008_web.pdf

¹¹ Reason Magazine. Ronald Bailey. Mandatory Health Insurance Now! November 2004

<http://www.reason.com/news/show/29303.html>

¹² Waiting for access, CBC News: In Depth: Health Care, November 29, 2006, accessed November 19, 2007 <http://www.cbc.ca/news/background/healthcare/waiting.html>

There is a severe shortage of medical professionals in Canada. In December 2008, the Society of Obstetricians and Gynecologists of Canada reported a critical shortage of obstetricians and gynecologists. The report stated that only 1,370 obstetricians were practicing in Canada and that number is expected to fall by at least one-third within five years.

Some doctors leave Canada to pursue career goals or higher pay in the U.S. Many Canadian physicians and medical graduates also go to the United States for post-graduate training in medical residencies. Often new and cutting-edge specialties are more widely available in the U.S. as opposed to Canada.

According to a 2007 article, the Canadian medical profession is suffering from a brain drain. The article states, "One in nine trained-in-Canada doctors is practicing medicine in the United States... If Canadian-educated doctors who were born in the U.S. are excluded, the number is one in twelve."¹³

There are Canadian restrictions on privately funded health care. The Canada Health Act, which sets the conditions with which provincial/territorial health insurance plans must comply if they wish to receive their full transfer payments from the federal government, does not allow charges to insured persons for insured services (defined as medically necessary care provided in hospitals or by physicians). Most provinces have responded through various prohibitions on such payments. So just as we have seen with American HMOs, the law makes it such that the private sector is unable to compete against the public. The system in Canada is anything but free.

The Moral Hazard of Unintended Consequences and Auto Insurance

Let's take a moment to think of the auto insurance industry. Have you had any work done to your car lately? Perhaps you just bought new all-season tires, finally got around to flushing your transmission fluid, or made your 3,000 mile pilgrimage to Jiffy Lube? Do you own your own home? Have you had to purchase any cleaning products lately? Have any light bulbs burned out? For each of these examples, you wouldn't think to charge these items to your auto or homeowners insurance would you? But that's exactly what most patients are asking of their health insurance coverage. It is no wonder health insurance is so expensive! Such examples follow the law of unintended consequences.

Auto and homeowners insurance policies are intended for catastrophic events; car accidents, flood, and fire. Restricting insurance claims to catastrophic events keeps premiums down. Sure, owning a home or a car can be expensive. But filing claims for maintenance, improvements or minor damage would increase premiums beyond a reasonable level. Imagine for a minute if people did have "free" auto insurance. Because car owners would not see the bill from Jiffy Lube, they would insist on getting the very best. Premium synthetic oil, top of the line tires, maybe a new transmission. And the

¹³ Canadian Press. 1 in 9 Cdn.-trained doctors work in the U.S. April 9, 2007
http://www.ctv.ca/servlet/ArticleNews/story/CTVNews/20070409/cda_doctors_070409/20070409?hub=Canada

fallout would not stop there. Because Jiffy Lube turns in all of its expenses to the auto insurance company, they would start selling \$100 oil changes.

Such a system represents what is called a moral hazard. In insurance markets, moral hazard occurs when the behavior of the insured party changes in a way that raises costs for the insurer, since the insured party no longer bears the full costs of that behavior.

Because individuals no longer bear the cost of medical services they have an added incentive to ask for pricier and more elaborate medical service—which would otherwise not be necessary. In these instances individuals have an incentive to over consume, simple because they no longer bear the full cost of medical services.

Coinsurance, co-payments and deductibles reduce the risk of moral hazard. Coinsurance, co-payments and deductibles increase the out-of-pocket spending of consumers. An increase in the amount individuals pay out-of-pocket or up front decreases their incentive to ask for more than they need, the insured have a financial incentive to avoid making a claim. Removing control over the health care dollar from consumers eliminates any incentive for consumers to pay attention to costs when selecting health care. As long as “someone else” is paying the bill, costs will continue to rise.

The Problem

The current system of third-party payers takes decision-making away from doctors, leaving patients feeling rushed and worsening the quality of care. Government already is involved in roughly two-thirds of all health care spending, through Medicare, Medicaid, and other socialized medical programs. The biggest problem we have is the cost associated with health care, with much of the money going to management companies, drug companies, and insurance companies.

Congressman and OB/GYN Ron Paul (R-TX) says: “It’s time to rethink the whole system of HMOs and managed care. This entire unnecessary level of corporatism rakes off profits and worsens the quality of care. But HMOs did not arise in the free market; they are creatures of government interference in health care dating to the 1970s. These non-market institutions have gained control over medical care through collusion between organized medicine, politicians, and drug companies, in an effort to move America toward “free” universal health care.”¹⁴

Medical Savings Accounts

Health insurance plans allow members to use personal Health Savings Accounts (HSAs), Health Reimbursement Arrangements (HRAs), or similar medical payment products to pay routine health care expenses directly, however a high-deductible health insurance policy protects them from catastrophic medical expenses. High-deductible policies cost less, but the user pays routine medical claims using a pre-funded spending account, often with a special debit card provided by a bank or insurance plan. If the balance on this account runs out, the user then pays claims just like under a regular deductible. Users

¹⁴ September 26, 2006. “Diagnosing Our Health Care Woes” by Ron Paul.
<http://www.house.gov/paul/tst/tst2006/tst092506.htm>

keep any unused balance or "rollover" at the end of the year to increase future balances, or to invest for future expenses. Using a tax-shelter such as an HRA or HSA puts the consumer back in control of the spending.

Free market health care alternatives, such as medical savings accounts, should be available to everyone, including senior citizens. The federal entitlement to Medicare should be abolished, leaving health care decision-making regarding the elderly at the state, local, or personal level.

The Solution is Consumer-Driven Health Care

While the costs of routine procedures have risen, the cost of elective procedures such as Lasik, dental whitening and plastic surgery has gone down. That is due to these procedures not being covered by insurance, and therefore providers must compete for your business.¹⁵

Private out-of-pocket treatment centers like RediClinic and MinuteClinic are rapidly popping up around the country. These businesses keep costs low, because they exist in a competing marketplace. Consumers with minor ailments such as sprains and head colds are getting treated for just pennies on the dollar. We need to return to the old U.S. system, where both patients and doctors have an incentive to keep costs down, where Americans paid cash for reasonably priced basic services, and have insurance only for major illnesses and accidents. There should be an incentive to spend less, not more.

Real patient protection flows from patient control. Only when patients hold health-care dollars in their own hands will they experience the protection and power inherent in purchasing their own insurance policies, making cost-conscious health-care decisions, and inciting cost-reducing competition for their cash. A system in which patients make the decisions on their costs will allow for greater economic benefit, where patients can choose to save, a system that incentivises patients to keep their money, if not spent.

Only true competition assures the consumer gets the best deal at the best price possible by putting pressure on the providers. Patients are better served by having options and choices, not federal bureaucracies and limitations on legal remedies. Such choices and options will arrive only when we unravel the HMO web rooted in old laws, and change the tax code to allow individual Americans to fully deduct all healthcare costs from their taxes, as employers can.

Health insurance should be left for catastrophic illnesses such as cancer treatments and heart transplants, not for sprained ankles and head colds. Only by putting the control back directly into the hands of the consumer will prices come down.

¹⁵ 20/20. Sick in America. John Stossel. http://www.youtube.com/watch?v=E_KCLm9cekU