HEALTH POLICY MATTERS

Brief commentaries on issues in U.S. healthcare, 2005-2012

by JARED RHOADS

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Preface

For the past seven years, since mid-2005, I have been very active in advocating for free-market ideas in healthcare and health policy. I ran a small but influential project that helped hundreds of medical students learn about the moral and economic case for capitalism in medicine; I attended and spoke at countless liberty-themed and Tea Party-related events; and I wrote and posted online over 150 article-length pieces on various health policy issues. There were many other things, too, but you get the idea.

The experience has been personally rewarding in many ways, and I do believe that all of the effort has made a difference. I'm glad I spoke up.

I've decided, however, to bring the student outreach project to a close, and to take a temporary break from writing. I'm shuttering the outreach project not out of lack of interest or demand on the part of the students–the main activity of the project was giving out free "kits" of books and essays to students, and there were always more students requesting these materials than inventory available–but rather out of a lack of time and resources on my part to grow and manage it in the way that it deserves.

The same goes for the writing. I'm still very interested and motivated to do it, but at the moment, it's a distant third priority behind my primary career as a healthcare industry researcher and consultant, and my family. Healthcare needs high-quality, original research, and strong, principled advocacy, and I would like to return to this someday, but this type of work simply cannot be done in brief spurts late at night or early in the morning, in addition to other major (chosen) commitments. It needs to be done full-time.

That leaves the question of what to do with the remnants of past efforts. With the student outreach project, there really isn't anything to archive or save. I could leave the website up, but that wouldn't serve any purpose. The writings, though, are a different matter. They are still usable. Looking back through them, the vast majority are still interesting and relevant. A few are obsolete, but most of them still say something worthwhile.

Hence this e-book. I've select a sample–quite literally a "top 40"–and put them into a single volume. I hope you find the look back interesting and enlightening, and I hope they are still as enjoyable to read as they were for me to write.

Jared Rhoads
Boston, Massachusetts
December 2012

September 20, 2012

If we didn't socialize healthcare costs, we wouldn't need a soda tax

By Jared Rhoads

President Obama has said that he "will not rest until the dream of healthcare reform is achieved in the United States of America."[1] For Obama, reform means offering government health insurance to roughly 46 million uninsured Americans, expanding Medicaid coverage to low-income individuals and families, and conferring sundry other benefits and handouts. These items do not come cheaply. A recent report by the Congressional Budget Office (CBO) estimated the cost to the government at more than one *trillion* dollars over the next ten years.

So who will pay for all of this, and how? One idea presented to the Senate Finance Committee is to introduce a federal excise tax on sugary beverages. Yes, under this proposal, Congress would institute a "soda tax."

The proposed tax would apply to sugary beverages such as soda, sports drinks, certain fruit drinks, and ready-to-drink teas. Most diet beverages would be exempt. According to the CBO, the tax would cost consumers about $0.03 per 12-ounce serving, possibly more, raising an estimated $24 to $51 billion dollars in revenue for the government over the next four years.[2,3]

Supporters of the proposal argue that the tax is necessary to combat the rise in obesity-related healthcare expenditures. Soda consumption increases costs, and under a government plan, costs are borne by "society." Therefore, consumers should be taxed.

That's their argument. But it is still not a reason why everyone has to finance everybody else's health insurance by way of government ruling. It's policy by collectivism. But individuals are not cells of a larger organism, bound to each other. They should be free to make their own choices as individuals, and bear the consequences individually.

Ayn Rand expounds:[4]

> *The moral and social ideal preached by everybody today (and by the conservatives louder than all) is the ideal of collectivism. Men are told that man exists only in order to serve others; that the "common good" is man's only proper aim in life and his sole justification for existence; that man is his brother's keeper; that everybody owes everybody a living; that everybody is responsible for everybody's welfare; and that the poor are the primary concern of society, its holy shrine, the god whom all must serve.*

The soda tax is not the start of some new slippery slope. We started down this road long ago with similar sin taxes on alcohol, cigarettes, cigars, and other products that lead to "socially undesirable behaviors." The more goodies we ask government to provide, the more power we grant to federal officials over our purses and our lives. It is a trend that needs to be reversed.

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[1] Young, J. "Obama 'will not rest' until healthcare reformed" The Hill, May 11 2009

[2] Adamy, J. "Soda Tax Weighed to Pay for Health Care" Wall Street Journal, May 12 2009

[3] Murray, S. "Congress Considers Beverage 'Sugar Tax' to Pay for Health Care" Washington Post, July 10 2009

[4] *The Letters of Ayn Rand*. The Fountainhead and Atlas Shrugged Years (1945-1959)

July 18, 2012

The individual mandate insults those who would self-insure

By Jared Rhoads

President Barack Obama and former Massachusetts Governor Mitt Romney have occasionally expressed different reasons for enacting their respective individual mandates, but both have defended the mandate approach on the basis that it eliminates free-riding.

President Obama has claimed that his mandate is based on an anti-freeloader principle: "It's less a tax or a penalty than it is a principle—which is you can't be a freeloader on other folks when it comes to your health care, if you can afford it."[1]

Likewise, Romney has explained that his team of health reformers "[insisted on] personal responsibility, [and said] to folks who could afford to buy insurance, 'either buy insurance yourself, or pay your own way.'"[2] Free-riding off the government, Romney wrote in a *Wall Street Journal* opinion piece, is not libertarian (his term).[3]

Is it any better to punish all people for the irresponsibility of a few?

Some people actually make an informed, rational choice to self-insure. They choose to defer consumption, set aside a portion of their income, and pay for their own care out-of-pocket. It is not appropriate for everyone, but for conscientious savers with low risk profiles, it can be an eminently sensible decision—especially considering the senseless array of coverage mandates in place today that drive up the cost of insurance and make all but make it impossible to get a tailor-made policy that truly fits one's needs.

The individual mandate leaves no room for legitimate self-insuring. It is a clumsy, blunt policy instrument that lumps together those who would prefer to save and pay for their care out-of-pocket with those who save nothing and show up to their local emergency room expecting free care. Respectable citizens who would otherwise self-insure must now purchase a policy they do not want, or be financially handicapped by a penalty—sorry, a tax—docking them of up to 2.5 percent of their taxable income.

One of the bullet points in Gov. Romney's presentation on healthcare last year at the University of Michigan read, "Personal responsibility means that everyone should be insured or have the means to pay for their own healthcare." Somewhere along the way in this whole debate, we lost that second option—allowing individuals the option to pay their own way—just as we lost the real meaning of individual responsibility years ago.

[1] Tau, B. “Obama: Health care mandate is a ‘principle’” *Politico*, July 17 2012

[2] Remarks by Mitt Romney at University Michigan Cardiovascular Center, May 12 2011

[3] Romney, M. “Health Care for Everyone? We Found a Way” *Wall Street Journal*, April 11 2006

June 28, 2012

One small win over the Commerce Clause, one giant defeat for health policy

By Jared Rhoads

The United States Supreme Court handed down its decision on the health reform law shortly after ten o'clock this morning. Contra the hopes and efforts of advocates of individual rights and limited government, the court ruled 5 to 4 that the health reform law be upheld. The court was of the opinion that every effort must be made to construe the minimum coverage provision (a.k.a. individual mandate) as a tax, and that therefore this particular type of coercion may be upheld as residing within Congress's power under the Taxing Clause.[1]

On the deciding issue, Chief Justice Roberts joined Justices Ginsberg, Breyer, Kagan, and Sotamayor for the majority. Justices Thomas, Scalia, Alito, and Kennedy dissented.

In short, the majority opinion preserves the mandate by interpreting it not as an unconstitutional command to purchase health insurance, but merely as a tax upon anyone who does not. As I've expressed before, that’s a distinction without a difference.

According to the Justices of the majority opinion, the Affordable Care Act may not be good policy, but it is not the court's job to protect us from Congress. An excerpt:

> *Our permissive reading of [the necessary and proper powers] is explained in part by a general reticence to invalidate the acts of the Nation's elected leaders. ... [W]e possess neither the expertise nor the prerogative to make policy judgments. Those decisions are entrusted to our Nation's elected leaders, who can be thrown out of office if the people disagree with them. It is not our job to protect the people from the consequences of their political choices.*

There was, however, one bright spot. A majority of the Justices concluded that the individual mandate could not be justified as an exercise of Congress's power to regulate commerce. Chief Justice Roberts held this opinion, along with Justice Scalia, Kennedy, Thomas, and Alito. An excerpt:

> *The Affordable Care Act is constitutional in part and unconstitutional in part. The individual mandate cannot be upheld as an exercise of Congress's power under the Commerce Clause. That Clause authorizes Congress to regulate interstate commerce, not to order individuals to engage in it.*

Elsewhere, some good verbiage in the dissenting opinion:

> *If Congress can reach out and command even those furthest removed from an interstate market to participate in the market, then the Commerce Clause becomes a font of unlimited power, or in Hamilton's words, "the hideous monster whose devouring jaws ... spare neither sex nor age, nor high nor low, nor sacred nor profane."*

In the big picture, though, these small wins offer little consolation. They do not alter the outcome of this case, which is that the Affordable Care Act stands in its entirety and more government interventions in healthcare continue to unfold. Furthermore, with such broad latitude now allowed in the tax code, who even needs to invoke the Commerce Clause anymore?

Today is an unfortunate day for advocates of free markets and proponents of a more objective approach to health policy. The court could have exercised—not just written about—a principle limiting the reach of the commerce clause, and thus the reach of government in general, which has seemed increasingly limitless in recent decades. But it did not.

More concerning, we can now expect a further institutionalization of the creed of self-sacrifice in public policy. The basic edifice of the Affordable Care Act was built upon extensive transfers and cross-subsidies from one group to another. Under the law, young people are sacrificed to the old, and health people are sacrificed to the sick. No other justification is given than reliance on the widely-held belief that one person's need constitutes a claim on another person's life.

The opinion echoes the language of the legislation, lending legitimacy to the collectivistic notion of a "shared responsibility payment." America is a nation of individuals, who voluntarily come together, or not, as appropriate for their individual interests. We do *not* share a responsibility for our brothers' health insurance policy.

In a free society, individuals would be assured that government would not intervene in the production and consumption of healthcare goods and services. Transforming our current system in a rational, orderly fashion is a major challenge. Clearly we are at least several decades away from that ideal. A serious attempt at health reform would begin with, for example, the equalization of tax treatment of health insurance policies purchased by individuals, or genuine opt-out and phase-out of entitlement programs like Medicare and Medicaid. It would not begin with social insurance like the President's 2010 set of reforms.

It is possible that this decision could galvanize a bigger, more morally certain movement towards a truly free market in healthcare. That is an optimistic view.

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[1] National Federation of Independent Business v. Sebelius, United States Supreme Court, 11-393 (2012)

April 13, 2012

Consumer-directed healthcare versus the "social equity" movement

By Jared Rhoads

At a recent event sponsored by the Pioneer Institute at Harvard Medical School, former CMS head Don Berwick and former OMB associate director James Capretta discussed the future of healthcare. The evening was billed as a conversation, not a debate, but it was attention-grabbing nonetheless. An official video is forthcoming from the institute.

Berwick, an advocate of government-driven healthcare, has a strong distaste for the market—a viewpoint seemingly arrived at by observing the shortcomings of the non-market that we have today and then attributing those flaws to capitalism writ large. He believes that private health organizations cannot be trusted, and that we need the government to ensure that everyone receives the necessary care they need. Of course, what would qualify as necessary care versus unnecessary care would still have to be decided by someone (in this case, the government), putting us back at square one.

New to me was the level of Berwick's disdain for consumer-directed healthcare. According to Berwick, the idea of empowering patients, giving them more responsibility, and more "skin in the game" is a "vicious idea." Even the *Boston Globe* reporter seemed a little taken aback at that.[1]

This is a consistent position, though, for one who asserts so vigorously that healthcare is a human right. As I commented on the page of a *Forbes* piece by Avik Roy, Berwick has made it abundantly clear that he regards healthcare as a human right.[2] He reiterated that assertion several times at this event. To him, consumer-directed healthcare is undesirable because it threatens social equity. The decisions that individuals make pertaining to what care they purchase and how much of it will not result in a flat distribution. Social equity proponents see this as a problem, and see government as the tool to fix it by redistributing care across society.

That approach comes at the expense of the free-market alternative, which is to free innovators to deliver increasingly better care at cheaper prices to an ever-broader market.

The onus of proof is on Berwick to show that government-driven healthcare is better–but he can't, because it is not better. Certainly there are challenges in areas like patient safety, quality, and outcomes, but to oppose private healthcare because it fails to achieve perfection is classic nirvana fallacy. What he falls back on is his moral claim that elevates social equity above all else. Equality, no matter what.

One thing on which I do agree with Berwick is that health reform is a moral issue. But whereas what he wants is institutionalized altruism, what we really need to rediscover is how to institute and protect a system of individual rights and rational self-interest. Then consumers will be able to direct their own care. And, like the advanced consumer electronic gadgets that are inaccessible at first but become available to the mass-market a few years later, there will plenty for everyone to access.

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[1] Conaboy, C. "What patients pay: Dr. Don Berwick and Jim Capretta debate shifting health care costs" *Boston.com*, April 6 2012

[2] Roy, A. "Ex-Obama Medicare Chief Don Berwick: Consumer-Driven Health Care a 'Vicious Idea'" *Forbes*, April 11 2012

March 25, 2012

Without a limiting principle, the individual mandate cannot survive

By Jared Rhoads

Starting on Monday, March 26th, the United States Supreme Court will begin hearing oral arguments in Department of Health and Human Services v. Florida, which will largely determine the fate of the President's 2010 health reform law. Many have called it the case of the century, and it's hard to disagree. At stake is whether the Affordable Care Act—the largest expansion of government into healthcare since the creation of Medicare—will be upheld in full, in part, or struck down in its entirety.

One of the key questions is whether Congress's authority to regulate economic activity, granted by the commerce clause, also extends to the regulation of economic *inactivity*. If the Supreme Court finds that Congress has the power to regulate economic inactivity, then Congress was acting within its power when it passed the individual mandate. People who do not have health insurance will be required to enter the market and purchase insurance.

Defenders of the law argue that Congress can regulate economic inactivity because *every* action that a person takes affects commerce in some way—even the "action" of not buying a good or service. Opponents of the law point out that under this interpretation, the power of Congress becomes unlimited. Congress could mandate individuals to buy practically anything that might lower healthcare costs—broccoli, gym memberships, Shake Weights, you-name-it.[1]

To win its case, the government must show, among other things, a) that Congress does have the power to regulate both activity and inactivity, yet b) there is some limit to that power (because to give Congress unlimited power would be unconstitutional). In other words, the government needs to demonstrate that there would still be some actions or inactions that would remain Constitutionally protected.

But if the Supreme Court agrees that Congress has the power to regulate both activity and inactivity, what else is there? What economic inactions would be unreachable under this view of the commerce clause and thus Constitutionally protected? The idea of any action being private could go extinct.

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[1] The individual mandate to purchase health insurance adds insult to injury in the sense that its alleged purpose is to fix a problem—free-ridership—that Congress itself created (by requiring hospitals to provide uncompensated care under the Emergency Medical Treatment and Active Labor Act).

February 13, 2012

Concierge physicians are now being targeted by regulators

By Jared Rhoads

According to a new rule that was passed in October and which took effect on January 1st, concierge physicians in Oregon are now required to register their practices with the state's insurance department.[1] To comply, concierge physicians and other doctors on retainer must share their business plan, financial history, and practice information with the state, submit marketing materials for review, and disclose any past bankruptcies going back 25 years.

The legislation was proposed by the state's insurance division. Insurers complained that, since concierge practices take a fee up front in exchange for care to be provided later, the practices are in the business of managing risk not unlike insurers. Their portfolio of clients, for example, cannot be allowed to exceed the capacity of the practice to provide the service promised.

Oregon's new requirement is the latest new piece of preventive regulation to be advanced in the name of "patient protection," which is merely an extension of the mostly-illegitimate consumer protection movement. But Oregonians do not need special protections from their doctors; they just need regular laws to be enforced if and when actual harm is perpetrated or breach of contract is committed.

As Ayn Rand wrote in 1962, "The right to be protected from physical injury or fraud belongs to *all* men, not merely to 'consumers,' and does not require any special protection other than that provided by *the criminal law*.[2] Aren't there existing penalties for fraud or breach of contract in Oregon?

The effect of Oregon's new requirement will not be to protect any actual patients. (The number of complaints made against concierge doctors statewide, by the way, is zero.) Instead, what it will do is waste the time and resources of busy physicians, and give regulators inappropriate access to private information. Somebody should call the Institute for Justice.

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[1] Berry, E. "Oregon requires concierge physicians to register with insurance department" *amednews.com*, February 1, 2012

[2] Rand, A. "Who Will Protect Us from Our Protectors?" *The Objectivist Newsletter*, May 1962

November 10, 2011

What size government do Americans want?

By Jared Rhoads

According to headlines running this week, a new poll has found that “a majority of Americans favor more government health services”[1] and “Americans want bigger government providing more healthcare services.”[2] But how accurate is that claim, which stems from the newly-released results of a telephone survey of 1,598 American adults published by the Robert Wood Johnson Foundation and the Harvard School of Public Health?[3]

In the survey, which was conducted for the two institutions by the social science research firm SSRS/ICR, there was only one question out of more than 30 that addressed this issue squarely. That question asked, “If you had to choose, would you rather have a smaller government providing fewer services in health, or a bigger government providing more services in health?” The responses were 37 percent in favor of smaller government, and 52 percent in favor of bigger government. Four percent said their answers depended on other factors, and seven percent did not know or refused to answer the question.

Although the question is careful enough to pair small government together with fewer services and big government together with more services, it does not really give an indication that there is any increased *personal* cost to bigger government. For an answer to this question to be fully contextual, one would have to take for granted that a random, nationally-representative sample of Americans would have this important fact in their minds. That is a hard sell. Among other things, I wonder how many respondents interpreted this simply to be a question about government efficiency or “return on investment.”

Certainly there is a need to avoid politically charged words in surveys. But wondering aloud for a moment, what might the responses have been for the following relatively mild alternatives?

> *If you had to choose, would you rather be taxed less and have a government providing fewer services in health, or be taxed more and have a government providing more services in health?*
>
> *If you had to choose, would you rather have fewer government programs intended to improve public health, or more government programs intended to improve public health?*

If you had to choose, would you rather live in a world with fewer government regulations intended to improve public health, or a world with more government regulations intended to improve public health?

The rest of the survey asked respondents about the priorities that the government should place on numerous public health objectives (e.g., preventing the spread of infectious diseases; providing screening tests for major health problems; preventing chronic illness), and to rate how well the government is performing against those goals. In some cases, it was possible for participants to say that the government should not be doing those things, but respondents had to volunteer that answer.

Sure, the results do not exactly reveal a pervasive, principled zeal for small government. But they don't exactly paint a picture of a populace brimming with enthusiasm for more big-government involvement in healthcare, either. For example, on half of the twenty objectives pursued by the federal government, more than a quarter of respondents rated the objective as "not a priority." And on question number four, a core question that asked respondents to rate how well the government protects the public from health threats and prevents illness, nearly twice as many people gave the federal government a failing grade (F) than a grade of excellent (A).

If these survey results show anything, it is that Americans' views on health issues is not monolithic, and that there is ample reason to question the value—or more likely, dis-value—that public health efforts produce. The results do not refute the fact that there is a large and growing portion of the population that favors smaller government in general, and less government involvement in health policy.

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[1] "Is Bigger Better When it Comes to Government Health Spending?" Robert Wood Johnson Foundation, November 7 2011

[2] "Americans want bigger government providing more healthcare services" *Healthcare Finance News*, November 9 2011

[3] "Americans' Health Agenda: Priorities and Performance Ratings" Robert Wood Johnson Foundation / Harvard School of Public Health, 2011

September 19, 2011

Presidential candidate Gary Johnson on reexamining EMTALA

By Jared Rhoads

On September 14, 2011, former New Mexico Governor Gary Johnson, who is running for the Republican nomination for the President of the United States, held an open-format Q&A conference call for writers and bloggers. For about an hour, he answered questions from those who called in, allowing everyone an opportunity to ask a question if so desired. The full transcript of the call is available to the public.

Although President Obama's jobs plan was the headline news of the day, attendees were free to ask questions on any subject. I asked Gov. Johnson whether he would be willing to reexamine, and possibly repeal, the Emergency Medical Treatment and Active Labor Act (EMTALA). EMTALA is the federal law that unfortunately has helped to make emergency departments the first refuge of patients, and has shifted costs from uninsured patients to patients with insurance. From the call:

> JARED RHOADS: Hi, thank you for having this call.
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> GARY JOHNSON: Absolutely.
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> JARED RHOADS: My question is about health care, under EMTALA, which is the Emergency Medical Treatment and Active Labor Act, hospitals are required to provide care to anybody who shows up at their emergency department. The hospital can bill the patient, but basically, the patient can't or doesn't pay.
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> JARED RHOADS: So, the hospital can bill the patient, but if the patient can't or doesn't pay, then the hospital has to absorb that cost. Would you ever consider opening up EMTALA for repeal or at least reexamination as part of your health reform?
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> GARY JOHNSON: Well, is that--is that federal?
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> JARED RHOADS: It is.
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> GARY JOHNSON: It is. Yeah, I think that would be one of the corner stones of the notion--or a great example of the notion that the federal government has to do away with all the strings and the mandates associated with Medicaid and Medicare currently. So that would be something that needs--that's one of those strings, that's one of those mandates that needs to be taken

> away, to give states the flexibility to deal with that kind of situation. I'm not saying I have the solution to all these problems, I'm just believing that if you give this to 50 states to figure out, that you'd have 50 laboratories of best practice, you'd have 50 laboratories of "Hey, we're going to do this better." Fifty competitive environments all out for best practice: that's what you'd have. You'd have best practice that would get emulated by other states. You know what? You'd have some pretty significant failure too, that would get avoided by other states. But the notion that one-size-fits-all, like you're pointing out, that's what has us bankrupt.
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> JARED RHOADS: Thank you.

The general public does not have a good understanding of the problems that EMTALA creates, so repealing the law would be an uphill, though proper, battle. Certainly it would be easy for Democrats and mainstream Republicans to advocate for keeping the law on purely altruistic and emotional grounds. But nevertheless it is refreshing to hear that someone in the public sphere is at least open to reexamining feel-good policies that have bad consequences, such as EMTALA.

June 10, 2011

Interview with Sally Pipes on health policy advocacy

By Jared Rhoads

Sally Pipes is a well-known advocate of limited government and free markets in healthcare. If you follow the national debate on health reform, then you probably know her name. Her writings frequently appear in publications like the *Wall Street Journal*, *Forbes*, and the *New York Times*. She also makes frequent speaking appearances, and once debated NY Times columnist Paul Krugman. A few weeks ago, she appeared at the Doctors Town Hall event held in Costa Mesa, CA, and gave a rousing account of what is in the health reform law and why it should be opposed.

Recently Ms. Pipes agreed to answer a few brief questions that I thought would be of interest to this audience. Without further ado, I present our interview.

> Jared Rhoads: You work for the Pacific Research Institute, a public policy group that promotes the principles of individual freedom and personal responsibility. Personally, how did you come to embrace those ideas?
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> Sally Pipes: I grew up in Canada, a country that in the 70s under the leadership of Liberal Prime Minister Trudeau, the country was moving quickly towards a society based on one of government control rather than individual responsibility.[1] This was of great concern to me. My family had taught me the value of personal responsibility and I believed it was the best way to maximize growth and entrepreneurship. Personal responsibility and liberty were very important to me and these principles were being eroded under his leadership.
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> Following graduation from university, I had the opportunity to join the Fraser Institute as a junior economist. Fraser was a new free-market think tank whose mission dovetailed with my own beliefs. It was the first think tank of this kind in Canada. One of the pillars of the Prime Minister's agenda was the takeover of the health care system by the government. He believed, as does President Obama, that it would lead to universal coverage at a lower cost. In the mid-1980s, I began to notice that as a result of this new single payer system, waiting lists for care were beginning to develop, care was starting to be rationed, and the technological advances in medical equipment and testing that were available in America, were not available in Canada. The health

care system which outlawed private payment for care has continued to deteriorate. In Canada today, the average wait from seeing a primary care doctor to getting treatment by a specialist is 18.2 weeks. With the election of Stephen Harper as Prime Minister, the first Conservative to have a majority government in 23 years, I am quite encouraged that changes will be made to the Canadian system which will introduce private alternatives to alleviate waiting times.

In 1991, I was offered the position to head up the Pacific Research Institute, which was established in 1979. Its mission mirrored that of the Fraser Institute and of my own values. The chance to come to the greatest country on earth was most exciting for me. America to me was the land of opportunity and entrepreneurship so the fit was a good one. Today, under the current regime in Washington, I am very concerned about the future of freedom and personal responsibility in this country. My goal is to fight to ensure that these principles are not lost and replaced by a society where government makes decisions for each of us. The passage of the Patient Protection and Affordable Care Act in March 2010 was very disturbing to me. Unless repealed and replaced, I believe that the United States is on a path to a Canadian-style "Medicare for All" system where government is the provider and controller of our health care. We will face the same consequences as in Canada--long waiting lists, rationed care, and a lack of access to the latest technology and treatments.

JR: Doctors are obviously a critical part of any effort to improve healthcare in America. How would you characterize their level of awareness and involvement in the health policy issues that you cover?

SP: Doctors are a very important part of health care reform. They have not been engaged in the policy debate in the past. Instead, they have been focused on building practices and offering the best medical care available. With many negative aspects of the PPACA now coming to light, doctors are now beginning to see the impact on their practices and are getting engaged.

I think it is important to note that America does not have a free market in its health care system today. Fifty percent of health care is in the hands of government through Medicare, Medicaid, SCHIP, and the VA system. It does concern me greatly that a growing number of doctors in the academy and hospitals favor a single-payer system. The medical schools where our young students are training for a future in medicine either as primary care doctors or specialists are being indoctrinated by their professors who constantly tell them that a government-run system would bring about affordable, accessible, quality care for all.

It was this realization in 2008 that medical school students were not hearing any alternative to this type of system that emboldened me to found the Benjamin Rush Society. It is patterned after the Federalist Society but for medical students and doctors instead of law students and lawyers. It is a chapter based organization with affiliates at over 20 medical schools around the country, from Duke to Harvard; from Stanford to George Washington University. The chapters hold debates and seminars on issues of importance on issues that should be important to them. Topics range from "How do you achieve affordable, accessible, quality health care?" to "Are pharmaceuticals too expensive?" to "Is universal coverage the responsibility of the federal government?" Our goal is to have a chapter at every medical school in the nation.

These debates are very informative for students. We find that about 65 percent of students in the pre-vote tend to support a greater role for government. Following the debate, some gains have been made, with about 60 percent supporting our position. There is still much to be done if we are going to save a health care system that empowers doctors and patients. It is worrying that 49 percent of newly graduating specialists are now working for hospitals rather than going into private practice. In recent polls, 45 percent of doctors have said that unless ObamaCare is repealed, they will seriously consider getting out of the practice of medicine. This has serious implications for all of us who will at some point need medical care.

In addition to the Benjamin Rush Society, there are a few organizations fighting for the rights of doctors to be able to practice medicine without allowing the government to take over the profession. These are Docs4PatientCare, AAPS, and Americans for Free Choice in Medicine. I can only hope that doctors and students get active and fight to preserve the doctor/patient relationship in our health care system. If not, where will the best doctors and where will we as patients go to get our medical treatment?

JR: If you were to give a talk about the health reform law (PPACA) to a group of medical students, what would be some provisions or implications that you would want to call to their attention?

SP: I would point out to them that under PPACA, they will lose their ability to practice medicine as they envisioned. The government will be making so many decisions about how doctors will be paid, what they will be paid, and what type of practice they can establish and operate. The setting of global budgets by government, the establishment of Accountable Care Organizations

for the treatment of Medicare patients, the IPAB (Independent Payment Advisory Board) which is a panel of 15 people appointed by the government that will oversee what doctors and hospitals are paid for treating Medicare patients, are all issues that are going to impede the practice of medicine. Also, it is unlikely that unless PPACA is repealed and replaced that the best and brightest young minds will pursue the study and practice of medicine.

JR: In 2008, you served as one of Rudy Giuliani's advisors on healthcare policy during his bid for the Republican nomination for president. What was that experience like, and do you have any plans to do something similar now that we're in the campaign season again?

SP: I very much enjoyed being part of Rudy Giuliani's team. It was a lot of work but most rewarding. Mayor Giuliani was very open to the kinds of market-based reforms that we recommended to him. This made our job of communicating his vision to the American people so very easy. Recently, I was asked to head the health care policy team for one presidential candidate but declined as I felt it was too early to join a particular campaign. As the election approaches, if I were asked to be part of a team whose candidate reflects my vision for health care reform or is at least open to new ideas, I would seriously consider being a part of it. I am so passionate about saving our health care system from turning into a single payer "Medicare for All" system like the one that I grew up under.

JR: Thank you, Sally Pipes, and we wish you continued success in your work!

SP: Thanks so very much.

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[1] Pierre Trudeau was Prime Minister of Canada from 1968 to 1979, and again from 1980 to 1984. Originally a supporter of socialist ideals, he eventually joined the Liberal Party of Canada. He is generally considered the father of socialized medicine in Canada.

June 2, 2011

On some aspects of health policy, Rand Paul is quite good

By Jared Rhoads

At a recent Senate subcommittee hearing on Primary Health and Aging, Senator Rand Paul from Kentucky made some good statements rejecting the notion that healthcare is a right. That's rare for a modern politician, and it's especially rare for a Senator.

The idea that healthcare *is* a right is supported by many in Congress, such as Representative Jim McDermott of Washington, Representative Sheila Jackson Lee of Texas, and Senator Bernie Sanders of Vermont. The line is usually the same. For example, as Senator Sanders puts it, "Every American has a right to the best quality healthcare that the system can offer, regardless of income."[1]

Opposing this, however, Senator Paul recently explained:

> *With regard to the idea whether or not you have a right to healthcare, you have to realize what that implies. It's not an abstraction. I am a physician. It means that you have a right to come to my house and conscript me. It means you believe in slavery. It means you are going to enslave not only me but the janitor at my hospital, the person who cleans my office, the assistants who work in my office, the nurses. If you have a right to their services... you are basically saying that you believe in slavery.*
>
> *Our founding documents were very clear about this. You have a right to pursue happiness, but there's no guarantee of physical comfort, there's no guarantee of concrete items. In order to give something concrete or someone's service, you've got to take it from someone. So there's an implied threat of force.*
>
> *If I'm a physician in your community and you say you have a right to healthcare, do you have a right to beat down my door with the police, escort me away, and force me to take care of you. That's ultimately what the right to free healthcare would be. If you believe in the right to healthcare you're believing basically in the use of force to conscript someone to do your bidding.*

Rand Paul deserves a great deal of credit for challenging the view that healthcare is a right. He questions not just the practical wisdom of socialized medicine but also the moral propriety of it. For those who advocate for free markets in healthcare not just because markets work but primarily because they are *morally* right, it is encouraging to see the discussion become richer and more sophisticated.

Let's take it apart. In one brief statement, Senator Paul accomplishes four good things:

- **He concretizes the issue from the perspective of the producers**. It's easy for advocates of healthcare as a right to speak of benefits while ignoring costs. It's much more difficult for people to dodge the implications of their abstract ideas when the ideas are translated to concrete actions. Senator Paul walks the committee through the ugly truth of what would be necessary to grant such a "right" (namely, the conscription of doctors).
- **He connects the fact that false rights require the use of physical force**. Senator Paul turns the tables on advocates of healthcare as a right by showing them that their position requires the initiation of force against innocent doctors and healthcare professionals. Of course, it is possible that these advocates view life as a violent class struggle and thus have no objection to the use of such force. But at least now they have to admit it openly or abandon their position.
- **He clarifies what is meant by the right to pursue happiness**. As the Senator says, the right to pursue happiness is not the same as a guarantee of success. A right is a freedom to act, not to collect the fruits of others. Some conservatives are courageous enough to make this point from time to time, but few make it with such moral certainty. Here, Senator Paul has earned the right to make this point because he is relatively consistent in his opposition to the use of force.
- **He introduces the controversial, but accurate, analogy of servitude**. No right can grant a good or service to one person if it requires the servitude of another person to provide it. Certainly the physical conditions of servitude for a doctor under socialized medicine are not comparable to those of a slave in ancient Rome or the colonial South—but the mental shackles are nothing to dismiss, either. The point is, servitude is bad in any dose.

Often it is taken for granted that involving government in medicine is moral, and that leaving medicine to the free market is immoral. This is backwards. The fundamental right that an individual has is to be able to live his life freely and not be interfered with. No man has the obligation to provide food, shelter, healthcare, or anything else. That principle holds true regardless of how necessary a good or service is.

Senator Rand Paul is not without some flaws, in my view. But on this occasion and others, he has demonstrated willingness and competence in taking the debate on healthcare to a deeper level. He has shown that he is not afraid to introduce some lucid thinking into what is supposed to be the most deliberative legislative body in the world.

On this issue, Rand Paul sets a good example. It would be nice to see others become emboldened and follow suit.

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[1] Testimony of Alieta Eck, M.D. at the Senate subcommittee hearing on Primary Health and Aging. May 11 2011

May 10, 2011

Wait times are on the rise in Massachusetts

By Jared Rhoads

According to new data released by the Massachusetts Medical Society (MMS), the situation with patient wait times and access to care in the Bay State is slowly worsening.[1] MMS notes that wait times to get an appointment with a primary or specialty physician remain long, and that half of primary care practices are not accepting new patients. Aside from a couple of mildly positive data points buried in the mix, the news for ambulatory care in post-Romney Massachusetts is not encouraging.

Below are the key data from the MMS report, which I have rearranged into groups of better, worse, and no change. The survey was conducted between February 16 and March 8 of 2011, and included 838 telephone interviews.

Regarding methodology, the researchers simply called physicians' offices to schedule an appointment with a new patient. Typical non-emergency reasons were given for each specialty (e.g., need a new PCP, heart check-up, new pediatrician). The overall results were weighted to ensure a representative sample by county.

Things that are getting better:

- 53% of family physicians are not accepting new patients (-1%)
- The average wait time for an internist is 48 days (-5 days)

Things that are getting worse:

- 51% of internists are not accepting new patients (+2%)
- The average wait time for family medicine is 36 days (+7 days)
- The average wait time for a gastroenterologist is 43 days (+7 days)
- The average wait time for an OB/GYN is 41 days (+7 days)
- The average wait time for an orthopedic surgeon is 26 days (+9 days)
- The average wait time for a cardiologist is 28 days (+2 days)

Unchanged:

- The average wait time for a pediatrician is still 24 days

The increased wait times group are eye-catching. However, there is a history of fluctuation with these numbers and it is difficult to say that a long-term trend has really formed. For instance, the average wait time for family medicine went up seven days this

past year, but in the previous year it dropped by 15 days. Today, at 36 days, it actually stands exactly at its five-year mean.

Looking at sustained trends over the last few years, the data for physicians accepting new patients are possibly a bigger cause for concern. Those numbers continue to fall pretty consistently. From the MMS report:

- From 2007-2011, the percentage of family medicine offices accepting new patients fell from 70 percent to 47 percent
- From 2005-2011, the percentage of internal medicine offices accepting new patients fell from 66 percent to 49 percent
- From 2005-2011, the percentage of cardiology offices accepting new patients fell from 92 percent to 82 percent

So despite the legislative efforts of Massachusetts politicians—or probably because of them—access to some of the most basic types of care in the state is falling. This affects everyone, not just people on government plans like Medicare or MassHealth, which is the Massachusetts Medicaid plan. (When the researchers who conducted this survey of physician offices called those offices to see if they were accepting new patients, they did not specify their anticipated payment method.)

For good measure, what about access to care for those residents who do have government-related insurance? As the MMS report notes, there is a significant gap even between the number of primary care physicians who accept Medicare and the number of primary care physicians who accept MassHealth. About 85 percent of internists and 87 percent of family physicians accept Medicare, yet only 53 percent of internists and 62 percent of family physicians accept MassHealth. Still fewer accept Commonwealth Care (43 percent of internists; 56 percent of family physicians) and Commonwealth Choice (35 percent of internists; 44 percent of family physicians).

The MMS data remind us that regular coverage does not equal care, and that coverage extracted by force through legislation *especially* doesn't equal care. What politicians ought to do is institute free-market reforms so that every patient regardless of their coverage is seen as a valuable customer and not a dead-weight loss. What I fear, though, is that as politicians and activists become enlightened to the disconnect between coverage and care, the idea of forcing physicians to accept new patients and mandating maximum wait times will gain luster.[2] What's next, a physician mandate?

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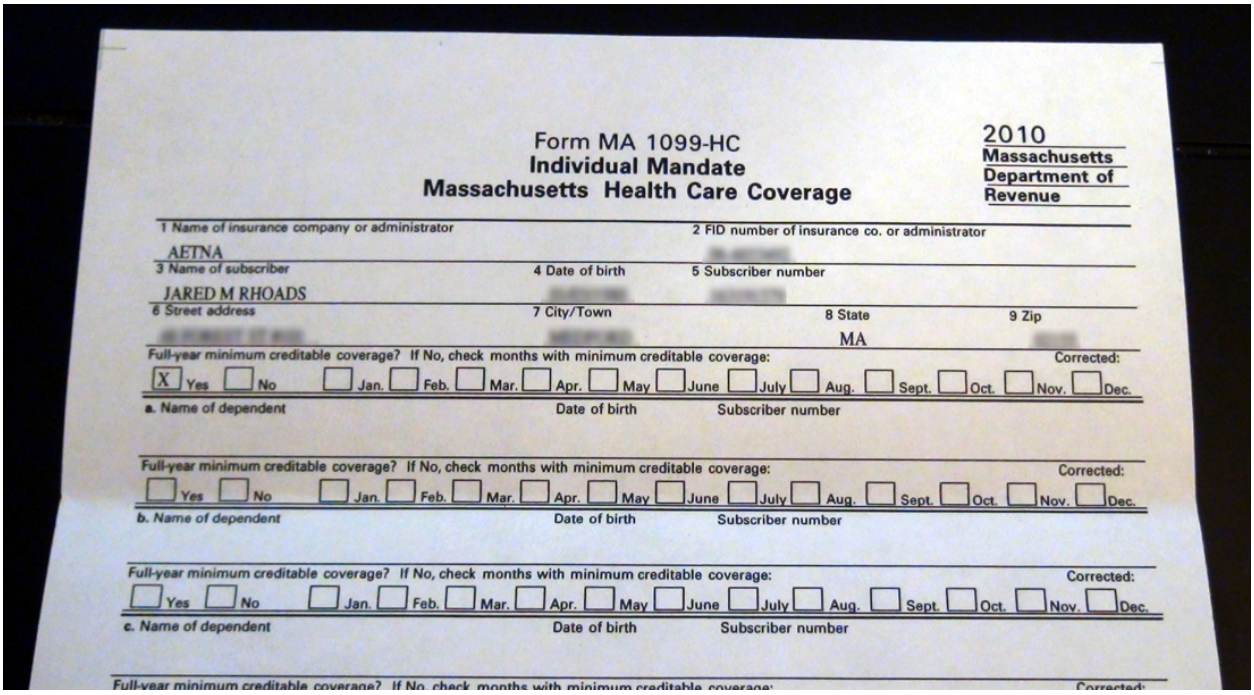
[1] "2011 Patient Access to Health Care Study" Massachusetts Medical Society, May 9 2011

[2] In the U.K., wait times for hospital care were so long that a political effort succeeded in setting maximums by law (as if that variable can be altered by decree without affecting other variables in the system). As of January 2008, the NHS promised patients that they would not have to wait longer than 18 weeks from the time they see their doctor to the time they get to a hospital for treatment.

February 2, 2011

My 1099-Romney

By Jared Rhoads



Form MA 1099-HC
Individual Mandate
Massachusetts Health Care Coverage

2010
Massachusetts Department of Revenue

1 Name of insurance company or administrator: AETNA
2 FID number of insurance co. or administrator: [redacted]
3 Name of subscriber: JARED M RHOADS
4 Date of birth: [redacted]
5 Subscriber number: [redacted]
6 Street address: [redacted]
7 City/Town: [redacted]
8 State: MA
9 Zip: [redacted]

Full-year minimum creditable coverage? If No, check months with minimum creditable coverage: Corrected:
[X] Yes [ ] No [ ] Jan. [ ] Feb. [ ] Mar. [ ] Apr. [ ] May [ ] June [ ] July [ ] Aug. [ ] Sept. [ ] Oct. [ ] Nov. [ ] Dec.

a. Name of dependent — Date of birth — Subscriber number

Full-year minimum creditable coverage? If No, check months with minimum creditable coverage: Corrected:
[ ] Yes [ ] No [ ] Jan. [ ] Feb. [ ] Mar. [ ] Apr. [ ] May [ ] June [ ] July [ ] Aug. [ ] Sept. [ ] Oct. [ ] Nov. [ ] Dec.

b. Name of dependent — Date of birth — Subscriber number

Full-year minimum creditable coverage? If No, check months with minimum creditable coverage: Corrected:
[ ] Yes [ ] No [ ] Jan. [ ] Feb. [ ] Mar. [ ] Apr. [ ] May [ ] June [ ] July [ ] Aug. [ ] Sept. [ ] Oct. [ ] Nov. [ ] Dec.

c. Name of dependent — Date of birth — Subscriber number

It's tax preparation time again. Among other things, that means gathering up the W-2s, the brokerage statements for Schedule D, the receipts from charitable organizations to which I donated, and the 1099-INT I received for earning four dollars in bank interest last year.

Am I forgetting anything? I'll give you a hint: I live in Massachusetts.

That's right, I need to get out my 1099-HC.

For the uninitiated living in the 49 less "progressive" states, the 1099-HC is the form needed by each Massachusetts resident in order to prove to the government that he had continuous health insurance throughout the prior taxable year. The "HC" in the name of the form stands for either "health care" or "health coverage"—I can never remember which. I just call it the 1099-Romney.

Yes, as a Massachusetts resident, every January I receive a 1099-Romney from my insurance carrier for the prior year. It shows the name of my insurance company, their federal identification number (FID), my subscriber number, and so on. If I had

continuous coverage with them for the entire year, then there will be an "X" in the "Full-Year" box. If I had coverage with them for only part of the year—say, January through June—then there will be an "X" in the box for each of those corresponding months, and the others will be empty.

We really do have to account down to month-level precision or face penalties. In 2009, my employer changed insurance carriers midway through the year. Sure enough, that year I got two partial 1099-Romneys, one showing coverage for the first part of the year with one carrier, and another showing coverage for the second part of the year with the other carrier. I had to submit the information from both of the forms onto the state's Schedule HC in order to show that I was covered for the full twelve months.

The individual mandate in Massachusetts is not a law without teeth, mind you. Failure to purchase coverage results in a penalty of $93 for each month without coverage. (A month is considered to be a month with coverage if the subscriber was covered for 15 days or more in the month. If a subscriber is covered for 14 days or less in a given month, then he is not considered covered and he will be fined.[1]) Going a whole year without meeting the coverage requirement results in a fine of $1,116 ($93 x 12 months). There are also penalties for employers and insurance carriers who fail to send out 1099-Romneys to their employees. That "crime" is punishable with a fine of $50 per employee, up to a maximum of $50,000 per year.

Since the state mandates that residents must purchase coverage, it must also dictate what kind of policy constitutes "minimum creditable coverage" (MCC). As always, controls always beget controls. In Massachusetts, you cannot purchase a low-cost, high-deductible policy, even if you believe that is the right coverage for you. Your coverage must include preventive care, and it can't have annual caps on total benefits. Above all, it must be comprehensive. Count me among those who are required to buy coverage for substance abuse despite zero history of, or tendency toward, ever needing this service.

So behold the 1099-Romney, and familiarize yourself with the process. This is the state experiment that served as the model for the individual mandate included in the federal health reform act and signed into law by President Obama last year.

Former Gov. Mitt Romney, meanwhile, continues to refer to the mandate that he instituted here in Massachusetts as the "ultimate conservative plan."[2] I wonder if Mr. Romney has ever seen the form that his legislation created. If not, now he can see mine.

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[1] "Form MA 1099-HC Questions" Massachusetts Department of Revenue. Accessed February 10 2010

[2] "Mitt Romney on RomneyCare" *Newsweek*, April 18 2010

January 19, 2011

Four brief observations about repealing the health reform law

By Jared Rhoads

Today the House of Representatives votes on whether to repeal last year's Patient Protection and Affordable Care Act (a.k.a. Obamacare). The bill in favor of repeal is expected to pass in the House but fail in the Senate. Unfortunately, there is far less drama this time. Even if the bill were to pass both chambers, President Obama would almost certainly veto it.

Nevertheless, permit me to share a few brief thoughts regarding the vote:

- **Today's vote is mostly symbolic, but that's okay.** Unless Senate Majority Leader Harry Reid changes his mind and agrees to bring up the repeal bill for a vote in the Senate, today's House vote is only for show. But in a nation suffocated by irrational and non-objective laws, any mention of the word "repeal" is apt to be a good thing. Today's action is not a waste of time. At the very least, it is one less afternoon that our Representatives can spend devising *new* ways to drag down the economy.
- **When the left tries to defend Obamacare, it's good for the right.** Very little in the health reform law is rationally defensible. Even allegedly popular measures such as forcing insurance companies to allow children to remain on their parents' health insurance up to the age of 26 are improper intrusions into private contracts. The much-touted savings are imaginary, as last year's episode with the Congressional Budget Office (CBO) demonstrated. Democratic spokesmen maintain that full repeal would mean "raising taxes on small businesses."[1]
- **Yes, Obamacare will kill jobs. But it could also kill people.** Republicans want to tie their repeal effort to the topic of jobs so that Democrats cannot accuse them of "fighting old battles" instead of "moving forward with jobs." But the issues of jobs and healthcare are complicated, and blending them together is not good for staying on message. The primary message for repealing Obamacare ought to be that it violates rights and endangers lives.
- **Opposition to Obamacare is not waning; people are just taking a break.** A recent poll says that support among registered voters for repeal may be falling slightly.[2] I doubt it. The opposition is not going away; they just have priorities to deal with on a day-to-day basis. This is January, and the new class of Congresspeople has barely taken office. Productive people with real jobs and real lives cannot spend every minute of their day doing what their representatives are supposed to be doing—*defending liberty*.

Today's repeal vote may only be a demonstration, but it sure demonstrates how quickly things can change in just one election cycle.

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[1] "Democrats, Republicans jockey for position on health care" *Politico*, January 18 2011

[2] "Independents Remain Steady..." *Resurgent Republic*, January 18 2011

August 24, 2010

The Stark anti-kickback rule needlessly stigmatizes physician self-referral

By Jared Rhoads

For years now, physicians who see Medicare and Medicaid patients have been required to comply with the suite of anti-kickback rules known as the Stark laws. The laws govern physician self-referral, and are intended to stamp out the alleged conflict of interest that arises when, for example, a physician refers a patient to a hospital or facility in which the physician has an ownership interest.

The latest expansion to the Stark laws is tucked away on page 1,534 of the health reform legislation signed into law by President Obama.[1] It specifically targets physicians who order MRIs, CT scans, PET scans, or "any other designated health services that the Secretary determines appropriate" for their Medicare and Medicaid patients.

As Kaiser Health News sums it up:

> *Under the new health care overhaul law, doctors who refer Medicare and Medicaid patients to in-house imaging machines must disclose in writing that they own the equipment. They'll also have to tell their patients they can get the services elsewhere, and provide a list of 10 alternative sites within 25 miles.*[2]

So if you are a physician working in group practice, and you determine that you can better serve your patients through faster turnaround or more consistent quality by having your own advanced diagnostic machines onsite, you might want to think twice before making that purchase. For starters, you will be forced to advertise on behalf of your competitors. But worse, you will be placing yourself in the crosshairs of yet another set of compliance auditors. And don't think for a moment that Congress would not someday pass a law to reduce reimbursement rates for services delivered in-house, in the name of equalizing "excess" profits. If that happens, it would come *after* you've committed to your million-dollar investment.

Self-referral is not an inherently pernicious business practice. It's the medical equivalent of vertical integration in the business world. Are consumers' rights violated when a automobile dealership opens up its own on-site service garage, or when Amazon.com recommends a book to a visitor and then provides the link to the Amazon page from which the book can be purchased? Of course not.

The only conflict here is artificial. It is introduced when the government inappropriately gets involved in paying the claims for what ought to be private transactions between

individuals. In a free market, physicians would be able to expand their service offerings without being presumed crooked. Meanwhile, in today's semi-free society, let the federal investigators of waste, fraud, and abuse direct their searches elsewhere. Let's show doctors and their patients some respect.

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[1] Patient Protection and Affordable Care Act, as signed into law by the President on March 23, 2010

[2] "Physicians must disclose if they own CT, MRI, or PET scanners" *Kaiser Health News*, August 23 2010

August 3, 2010

Interview with Peter Schiff

By Jared Rhoads

Peter Schiff is known to many as the economist and investment advisor who predicted the crash of the housing market at a time when nearly every public figure maintained that government efforts to inflate the bubble would never backfire. These days he can be found on the campaign trail, working to close the gap in the race for U.S. Senate. The Connecticut Republican Primary on Tuesday, August 10th, will determine who will face Democrat Richard Blumenthal in the general election: Mr. Schiff or his opponent Linda McMahon.

I recently met up with Mr. Schiff at one of his campaign events in Connecticut to ask him a few questions about healthcare. It turns out he is as consistently in favor of individual rights and free markets in healthcare as he is in most other issues.

According to Schiff, for example, government should not be involved in dictating the medical decisions of private citizens or manipulating the healthcare industry. He wants to free workers from the trap of employer-provided health insurance by allowing individuals to receive their employer's contributions as tax-free wages instead. He also wants to end insurance mandates, open up health insurance markets to interstate competition, and reduce costs by addressing problems with medical malpractice laws.

Here is the brief interview.

Jared Rhoads: Earlier this year, Congress passed its version of health reform. How do you think this legislation will affect costs?

Peter Schiff: Well, you know, whenever Congress intends to do something, they achieve the exact opposite. And what this bill is going to do is make healthcare more expensive, make the insurance premiums rise even faster, and reduce the quality and the availability of healthcare in the United States.

JR: There is a legal effort underway to challenge Obamacare, and a political effort to repeal it. How successful do you think either will be? PS: Well I don't think it will be repealed. Obama is not going to sign that, so that's not going to happen anytime soon. It is completely unconstitutional, but our courts are notoriously bad when it comes to enforcing the Constitution. Just about everything the government does is unconstitutional, so why should healthcare be an exception. So I'm not too optimistic that we're going to get justice in the courts, because they tend to let the U.S. government do whatever it wants.

JR: You're in favor of phasing out Medicare. Have you been successful in communicating to voters your reasons for that position, or is that too emotional an issue for voters?

PS: It's an unfunded liability of thirty trillion plus, so it's going to bankrupt us. The only question is, do we find a way out of the situation or do we wait for a crisis? I prefer the former. And you have to understand, why is healthcare so expensive? The reason is government involvement in the process. If we had a free market in healthcare, if we had a free market in insurance, there wouldn't be a problem. It wouldn't be so expensive. Healthcare would be getting cheaper every year. After all, with all the new technology and medicine, it should be cheaper, just like cell phones or plasma TVs. Markets bring prices down. That's what happens as you get economies of scale and you become more efficient. But we're being denied that because of government interference.
There *are* things that we can do to bring down healthcare costs. And it would fall dramatically if we'd simply repeal those regulations that are responsible for the increase. It wouldn't cost the taxpayers anything. The most important thing we can do remove the subsidies for insurance, because people are over-insured. People treat insurance as pre-paid medical. But insurance doesn't work that way. Insurance is for things that are not supposed to happen, or are very unlikely, or are catastrophic

and would be expensive. You don't have insurance for the flu or for a sprained ankle, or for childbirth. These are things we know are going to happen and these are things we should save our money for and pay for out of our pocket. When we do that, there are market forces, and people shop around. If you look at medical care that is not covered by insurance, like eye Lasik surgery, the price comes down every year. It's cheaper to get the surgery today than it was five years ago. And it's more effective. The same thing with cosmetic surgery. That's getting less expensive. In fact one of the reasons that the best and brightest doctors want to go into cosmetic surgery is because there's no insurance. And so we need to get the government out, and that is a function of the tax return.

The government has to stop subsidizing insurance so that employees can get wages instead of healthcare benefits. And then they can buy the insurance they want, and they'll care about the cost. And if we get the insurance companies out of it, we can get price discovery. We can get people competing on price. Doctor's don't compete on price right now because nobody cares about the price, because somebody else is paying for it.

My father, who was an insurance agent, before Medicare came along his most popular policy was two dollars per month. That's what it cost for health insurance in this country!

JR: He was selling health insurance?

PS: Yeah, he was an insurance agent. You know, back then people didn't get their insurance from their employer. They bought health insurance the same way they bought life insurance, automobile insurance, fire insurance, and we're not having a crisis in those areas. You don't have your car insurance going up ten or fifteen percent a year because we buy it ourselves, unlike health insurance. So we need to get the government out of it. We need to get the government to stop mandating that the insurance companies cover everything so that we can buy policies for things that we want to cover, not the things that other people think they should cover. It's like, what if you had to buy a car, and every car had to be fully loaded? You had to get the sports wheels, and you had to get a sun roof, you had to get GPS. You couldn't just buy the basic car. Nobody could afford it. Why can't you buy basic catastrophic insurance without covering mental issues, alcohol abuse, all the things that people might not want. We should have interstate competition--we should have *international* competition! But it's illegal for Swiss insurance companies to offer insurance to Americans. Why? Why can't I buy insurance from a Japanese insurance company? We can buy foreign cars, why can't we buy foreign insurance?

Competition is good. It brings down prices. So get government out and we won't have to worry. You know, so much medicine is

defensive, and malpractice insurance is so high. One of the reasons we have a shortage of doctors is because they can't afford the insurance we've made mandatory for being a doctor. So there's so many ways government is screwing up healthcare. And now since they screwed it up so much, now they're proposing this Obamacare. This is the camel's nose under the tent, because this is going to fail.
This is going to be the beginning to single-payer, socialized medicine. That is what's coming. Because the government constantly interferes with markets, they screw it up, and then blame the problems on the free market, even though it's their fault. And then they use that as an excuse to get even more involved. And ultimately they completely screw it up. If you're going to want to get healthcare, you're going to have to go to another country for it.

JR: If you had the opportunity to address a roomful of medical students, what advice would you give them?

PS: I think that most likely, if we don't change course, they should also study a foreign language while they're in med school because that's where they're going to be practicing if they wanted to have the type of career that they envisioned!

JR: Thank you Peter Schiff, and good luck on the campaign trail.

PS: Thanks!

I'd like to thank Mr. Schiff and Vivian Nasiatka, the 5th District Field Representative for the Schiff campaign, for helping to arrange this conversation. I wish him well in his Senate bid.

March 31, 2010

Seven ways the new health reform law initiates force against insurers

By Jared Rhoads

The new health reform law, known officially as the Patient Protection and Affordable Care Act, was signed into law last week by President Barack Obama. The final version was chock-full of all the intrusive government controls that many writers and analyst had warned about.

The Act is not good news for health insurance companies. Seven examples:

Sec. 2711 forces health insurance companies to remove without lifetime limits from all of the plans they offer. Insurers are also prohibited from having an annual limit on benefits that are deemed by the government to be "unreasonable."

Sec. 2713 forces insurers to include preventive services and immunizations, with no cost-sharing.

Sec. 2718 forces insurers to report the percentage of premium revenue that they spend on care, and (up until the year 2013) refund their customers if the percentage is not to the government's liking.

Sec. 2702 forces insurers to accept every employer and individual that applies for coverage, regardless of just about any factor that might matter, such as health status or utilization of services. The government calls this guaranteed availability and renewal.

Sec. 1104 forces insurers to comply with uniform standards and operating rules for the way they communicate and do business with providers. These standards, of course, will be developed by the government. This is HIPAA redux.

Sec. 2704 forces insurers to ignore all relevant facts about an individual's current health, health risks, or health history when offering coverage.

Sec. 1343 forces insurers to pay penalties if their enrollees are deemed to have lower-than-average risk. (This is a clever way of automatically putting fifty percent of health plans on the ropes each year.)

With the stroke of a pen, the President has begun the systematic dismantling of an entire industry. He should know that insurance is a type of contractual agreement that enables individuals to share risk in exchange for compensation. He should know that

insurance is a brilliant financial invention and a win-win arrangement when both sides are free to act voluntarily in the context of a free market.

But thanks to a moral code that tells him that profit is evil and that people ought to sacrifice for one another, he does not know these things. And neither does 98 percent of Congress.

In the immediate aftermath of this Act, things will seem normal. Nobody will die today or next week as a result of these government actions. Consequences take time. But when the effects do materialize, people may realize who is responsible and why these actions are so inexcusable. “Whoever, to whatever purpose or extent, initiates the use of force, is a killer acting on the premise of death in a manner wider than murder: the premise of destroying man’s capacity to live.”[1]

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[1] Ayn Rand. “Galt’s Speech” *For the New Intellectual*. p133

March 17, 2010

Will any politician debate healthcare on philosophic fundamentals?

By Jared Rhoads

Are you one of the four to nine percent of Americans who is still undecided about the current health reform proposal? Perhaps you've heard the Republican and Democratic talking points and you believe that both sides have good points and legitimate concerns. Or, more likely, perhaps you believe that neither side has any credibility and that both are incapable of bringing about real reform.

You have been denied the benefit of an *actual* debate on health reform.

For the past twelve months, the Obama administration and Democratic leaders in the House and Senate have been telling us how open they are to new ideas. At the 2009 March healthcare summit held at the White House, the President stipulated that "every voice has to be heard" and "every idea must be considered." In September, he told a joint session of Congress that "we should remain open to other ideas." Last month at the Blair House summit, he reiterated: "[I]f we've got an open mind, if we're listening to each other... we might be able to make some progress."

After all that listening, and nary a paragraph of health reform legislation that doesn't entail an expansion of government power or control. No free-market reforms. Not even a half-hearted attempt at medical malpractice reform. To *whom* are the Democrats listening—each other?

The left does not want to listen to free-market arguments. But what is more, the right does not want to offer them—at least not in any principled manner. It is impossible for Republicans to do so when just seven years ago they were responsible for passing Medicare Part D, the largest Medicare expansion since the program's inception. Sure, some Republicans have argued in favor of deregulating the insurance industry to allow interstate competition. But they justify their position on the basis of economic benefit of increasing competition, not the much stronger and more fundamental case of protecting the rights of producers and consumers.

Last summer when President Obama was pushing the public option, did the Republicans respond by defending property rights (which would have been good) or by challenging the moral notion that one ought to be one's brother's healthcare financier (which would have been better)? Of course not. Instead, Olympia Snowe (R-ME) presented a "trigger option" that would merely delay the public option and make it

contingent upon a future government determination of “coverage affordability” in each region.

Some Republicans have done better than others in defending individuals against the leviathan, but this has only been possible with the moral courage on loan from the Tea Party movement and select activist organizations. What little genuine debate there is on fundamental ideas has come almost exclusively from American citizens, not our political leaders.

In 1854, Henry David Thoreau wrote, “There are a thousand hacking at the branches of evil to one who is striking at the root.” Ayn Rand was one such thinker. She brought down the tree of political collectivism by striking at its root, the doctrine of self-sacrifice. She questioned those who taught that individuals exist for the benefit of the group. She provided a rational defense for the protection of life, liberty, and the pursuit of happiness, and exposed the incompatibility between freedom and force. Democrats and Republicans: if you are ever ready to start a real debate on health reform, start with her.

January 26, 2010

The real meaning of Scott Brown's victory in Massachusetts

By Jared Rhoads

It is both amusing and frustrating to watch Republicans and Democrats try to make hay out of Scott Brown's victory in Massachusetts. Republicans assume that Brown will eventually warm up to big-government conservatism and support the entitlements and programs of the right. Meanwhile, Democrats rationalize that Brown won by tapping into "the same voter anger" that put them into office in 2008.[1]

Some Democrats, for example Howard Dean, have gone so far as to claim that voters elected Brown because the House and Senate bills were not leftist enough.[2]

The truth, however, is that Scott Brown was elected by neither Republicans nor Democrats. He was elected by a large middle-class contingent of independent-minded voters, most of whom want the federal government to get out of their wallets and out of their private lives.

Brown explicitly ran on the promise that he would be the vote that would block health reform. On the campaign trail he signed autographs "Scott 41" and told crowds he would kill the trillion-dollar Democratic mega-bill. The threat of a single mega-bill may be past, but now Democratic leaders are concocting a plan in which Congress passes the Senate bill (which is unpopular in the House) while Nancy Pelosi and Harry Reid cut a deal to guarantee that House-friendly provisions are added later. This approach does not require a supermajority, so Brown's 41st vote will not stop anything.

Whether Republican or Democrat, anyone who wishes to be the voice of the independent majority needs to understand that voters don't want Obamacare in any way, shape, or form. We want to enact the one political philosophy that would represent true hope and change in the United States: constitutionally limited government.

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[1] Several elected officials have made this claim, including President Obama and Massachusetts governor Deval Patrick.

[2] See Howard Dean's appearance on MSNBC's television show *Hardball with Chris Matthews*, aired January 20 2010.

November 5, 2009

What we have in healthcare is not a free market

By Jared Rhoads

Advocates of government-run public option health plan are fond of claiming that the market "has been given its chance" and that all we need now is for the government to "inject competition into the health care market so that [we can] force waste out of the system and keep the insurance companies honest."[1] Yes, the President of the United States associates *force* with the *market*, and *choice* with the *government*—not the other way around.

Perhaps the scariest thing is that most of Congress agrees.

With a public option back on the table, Congress is poised to pass what would, in effect, be a massive new entitlement program paid for explicitly through a combination of payroll penalties on employers (i.e., displaced wages) and confiscatory taxes on the rich. Since that won't be nearly enough to cover the real expenses of such a plan, the balance will likely be covered through general taxes and inflation, both of which tend to hit middle-class savers the hardest.

If anyone believes the government assurances that the plan will be self-sustaining—after $2 billion in government startup funding, of course—just look at the books of Medicare, Fannie Mae, and Freddie Mac.

Boston Globe columnist Jeff Jacoby recently wrote about health insurance reform in a piece calling for less government and more markets.[2] Here are his top three reforms. I agree with them and have advocated for them myself. All are desperately needed, and any one of them would be a major breath of fresh air:

- **Tear down the barriers to buying insurance across state lines.** When it comes to almost any other product or service, Americans would find a ban on interstate commerce and competition intolerable: Imagine being told that you could buy a car only if it was manufactured in your state. Consumers in the market for a mortgage are free to do business with an out-of-state lender; those in the market for health insurance should be equally free to do business with an out-of-state insurer.
- **Repeal mandatory benefits that make health insurance needlessly expensive.** Compounding the lack of interstate competition is the way states drive up the cost of health insurance by making certain types of coverage compulsory. Consumers and insurers should be free to work out for themselves just how comprehensive or limited a policy should be. But state mandates prevent such flexibility by requiring

insurance companies to sell a fixed array of benefits that many customers may not want. Individuals seeking plain-vanilla health insurance—a policy that will cover them, say, in case of major surgery or catastrophic illness—may find themselves forced to pay for a policy that also covers acupuncture, in vitro fertilization, alcoholism therapy, and a dozen additional treatments.

- **De-link health insurance from employment.** Nothing distorts America's health insurance market like the misbegotten tax preference for employer-sponsored health insurance. Until that preference is removed, millions will continue to rely on their employers' health plan, rather than buying insurance for themselves. Fix the tax code, and no longer could insurance companies routinely bypass employees and deal only with their employers. Instead we would see intense competition for individual customers—and the lower premiums such competition would yield.

The market is not suffering for a lack of government control; it is suffocating from too many controls. How can insurers compete effectively when they have to sell into fifty different markets with fifty different sets of arbitrary rules? How can patients and consumers shop for what they need, when what they must buy is dictated by federal and state governments? And who is going to expose themselves to additional tax penalties by forgoing employer insurance in exchange for buying a policy in the current individual market?

The current insurance market is so hampered by government controls that it cannot even seriously be called a market. If you went to buy an apple at a fruit stand, and a third party intervened in your transaction telling you which type of apple to buy, from whom, at what price, could you really call that a market transaction? Of course not. (And by the way, the intervener also tells you that you have to buy an apple, and that you are not allowed to manage your diet or hunger in any other way—that's the individual mandate.)

What is needed is not just a defeat of the current House and Senate bills, but the proposal of a wholly new bill that enacts real market reforms. Real market reforms make markets more free, not less free.

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[1] Obama, B. "Remarks to the American Medical Association" Chicago, Illinois. June 15 2009

[2] Jacoby, J. "An option for public: less government, more choice" Boston Globe, November 4 2009

May 12, 2009

Government is for protecting rights, not selling insurance

By Jared Rhoads

A letter to the editor in yesterday's edition of the *New York Times* calls for health insurance companies to be forced to compete with a public health plan administered by the government. "And if they fail," the writer goes on, "they should get out of the health insurance business."[1]

Compete? What a strange concept to use in a scenario in which one competitor deals by voluntary trade, and the other deals by force.

Private insurers compete with each other to provide the best product they can on the market. Their costs are based on the payments that they can negotiate with providers, voluntarily. Their revenue is based on the number of customers they can attract, voluntarily. These companies are contractually obligated to provide that is clearly stated in the policies they underwrite. Many of these companies are quite large. Dealing with them can sometimes feel impersonal. But no matter how big they are, they cannot "wield power" capriciously, break contracts arbitrarily, or force you to subsidize your neighbor's premium. Consumers have recourse if they do.

The government, on the other hand, has no other way but to deal by force.[2] It gets price advantages by strong-arming providers (and will almost certainly be dictating care options before President Obama's term is over). It gets operational advantages by hamstringing the private industry with regulations. And whatever revenue the government cannot raise from premiums, it can confiscate via taxation and inflation.

Many advocates of the public option proudly acknowledge that their plan amounts to one massive Medicare-for-all program that would likely have the effect of wiping out the insurance industry altogether. Medicare, the program that is riddled fraud and abuse and which now faces insolvency as soon as 2016 or 2019.[3] The purpose of the public option is political, and if it is allowed to be implemented, the results will be ugly.

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[1] Blaine, M. "Re Schumer Points to a Middle Ground on Government-Run Health Insurance" *New York Times*, Letter to the Editor, May 12 2009

[2] The delegation of force to the government is appropriate only for the purpose of protecting individual rights. This is true for the military, police, and court system.

[3] Will, G. "Dr. Leavitt's Scary Diagnosis" *Washington Post*, January 1 2009

April 27, 2009

If you want to prevent a doctor shortage, get the government out of medicine

By Jared Rhoads

The *New York Times* featured an article yesterday on the concern over how the growing shortage of doctors may hinder President Obama's goal to provide healthcare to millions of Americans who are currently uninsured.[1] "We're not producing enough primary-care physicians," the President said the White House Summit on Health Reform in March. With barely enough individuals to provide care already, the administration realizes that its goals of expanded coverage and greater access for millions may be an empty promise.

Will this finally lead Washington to recognize the primacy of production over consumption (i.e., the crucial importance of doctors in the delivery of care)?

No. Instead, acknowledging that fewer young doctors go into primary care due to lower pay, the administration has proposed increasing Medicare reimbursements to general practitioners and paying for it by way of decreasing payments to specialists. If they do that, then in four years we will be right back here, lamenting the shortage of specialists.

Far be it for me—or anyone else—to say exactly how many generalists we should have versus specialists, or oncologists versus pulmonologists, or whether we should throw all of our resources behind increasing the number of nurses, physician assistants, or other caregivers. Maybe what people would really prefer is more chefs, comedians, and hair stylists. No person or agency can know this in advance, which is why we need to rely on the market—a vast, free, self-correcting market—to adjust these things in accordance to supply and demand. Under capitalism, shortages do not last; they are corrected through continual adjustments.

But we do not have a market. Instead we have a system in which the government acts as third-party payer for over 50 percent of national healthcare expenditures, setting reimbursement rates through confusing, arbitrary schedules that are updated at a comparatively glacial pace. These rates, coupled with restrictive regulations on who can provide what kind of care and to whom, act as de facto price controls. Price controls result in shortages, every time.

Political commentator Glenn Reynolds of Instapundit piles on with another good point:

> *We don't produce doctors. They're not widgets. People choose to become doctors—or something else—based on their analysis of what will produce the*

best life. Medicine has gotten less pleasant, and less financially rewarding over the past several decades as it has become more bureaucratized and subject to the whims of third-party payors. So will Obama's plan fix that? Seems doubtful. Will he recognize that you don't produce doctors the way you produce, say, cars? That's doubtful, too.[2]

The only civilized way to entice more individuals into the areas in which they are needed is to allow the market to compensate them objectively. Generalist, specialist, or otherwise, it is not for the government to decide. What are the optimal amounts at a given point in time? No government administrator can tell you. That's what markets do.

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[1] Pear, R. "Shortage of Doctors an Obstacle to Obama Goals" *New York Times*, April 26 2009

[2] Reynolds, G. Instapundit weblog: http://pajamasmedia.com/instapundit, April 27 2009

March 31, 2009

Let the market determine which treatments are effective

By Jared Rhoads

Last month, President Obama signed into law the American Recovery and Reinvestment Act, a piece of legislation intended to stimulate the economy by "laying the groundwork" for recovery with smart investments in infrastructure, jobs, and research. Among the many provisions for healthcare, the act sets aside $1.1 billion for government research to determine which treatments, drugs, and technologies are the most effective in preventing, diagnosing, and treating various conditions and disorders.[1]

From a strictly medical perspective, this type of research is intriguing because the precise risks and benefits of many treatment options are unclear, and often it is not understood why some therapies work for some patients and not for others. But why is this any business of the federal government?

Supporters of the research defend the spending on the grounds that it will help to make programs such as Medicare less wasteful. Comparative effectiveness research, they say, will ensure "responsible stewardship" of the public's funds by allowing the government to pay only for what works.[2] For example, if researchers find that some cheaper alternative works just as well across a population as a more expensive treatment, then the government could change the Medicare reimbursement structure to provide an incentive for the former and a disincentive (or outright penalty) for the latter.

Interestingly, such uses of the research findings are explicitly prohibited in the text of the Act. Section 804 stipulates that the law shall not be construed to permit the Federal Coordinating Council to mandate coverage, reimbursement, or other policies for any public or private payer based on the findings of researchers.

But that will not stop the government. In due time, Congress will strike, amend, ignore, or "provide clarification" such that it will be possible for the government to use these findings to substitute the cheapest possible care for patients, Canadian-style. Guaranteed. After all, if the findings cannot be used to inform policy making, then why bother doing the research at all?

Investing taxpayer money in the name of delivering care more efficiently does not change the fact that there is no rational justification for government involvement in healthcare in the first place. If a man is robbed at gunpoint, does it make any difference how carefully and "effectively" the thief spends the loot?

The purpose of government is to protect rights, not play universal problem-solver for all manners of health and welfare needs. To even discuss the alleged merits of such research is to evade the source of the funds (confiscatory taxes) and lend credibility to those who seek to expand the reach of government into medicine.

Comparative effectiveness research sets the stage for an unprecedented increase in the government's power to control what treatments providers can prescribe and to whom. We already have a mechanism by which to determine and reward best practices: the free market. But unless the market is allowed to operate unhampered and unfettered, we will never escape the cycle of programs breeding programs.

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[1] H.R. 679; 111th Congress (2009): American Recovery and Reinvestment Act of 2009

[2] Paduda, J. "The horrors of effectiveness research" Managed Care Matters. In his article, Paduda writes: "I'm completely disgusted with the hypocrisy of the libertarian right; those who have screamed for years about the ineffectiveness of government, ranting nonstop about how government can't do anything right, yet are now screaming even louder as government attempts to make sure they are responsible stewards of the public's funds."

March 9, 2009

Patient privacy and the National Health Information Network

By Jared Rhoads

For years, federal officials have been maneuvering themselves into position to create a national information network for the exchange of health information. A variety of research efforts and demonstration projects have been tried in Utah, Tennessee, Rhode Island, Indiana, and other states, in order to lay the foundation and elicit best practices for the big day when a national effort could be launched. Now, the recently-passed stimulus legislation gives them the power and funds needed to do just that.

The American Recovery and Reinvestment Act (ARRA) includes an entire set of healthcare information technology provisions, referred to separately as the Health Information Technology for Economic and Clinical Health (HITECH) Act. Among other things, it gives the Department of Health and Human Services the authority and resources to accelerate development of a "nationwide health information network" (NHIN).[1] The goal of the NHIN will be to "connect providers, consumers, and others involved in supporting health and healthcare."[2]

Among other things, the act empowers the National Coordinator to make broad policies with respect to:

- *The electronic exchange and use of health information and the enterprise integration of such information.*
- *The utilization of an electronic health record for each person in the United States by 2014.*
- *Strategies to enhance the use of health information technology in improving the quality of health care, reducing medical errors, reducing health disparities, improving public health, increasing prevention and coordination with community resources, and improving the continuity of care among health care settings.*

Given the way agency powers are interpreted these days, that is practically a blank check for the agency to do whatever it wishes.

With regard to privacy, the legislation instructs the government agencies in charge of the NHIN to incorporate "privacy and security protections for the electronic exchange of an individual's individually identifiable health information." The legislation also creates a separate policy committee and instructs it to come up with recommendations for "Technologies that allow individually identifiable health information to be rendered

unusable, unreadable, or indecipherable to unauthorized individuals when such information is transmitted in the nationwide health information network."

I, for one, would prefer that my health information not be available via federally-governed network at all. But I don't expect to be asked for my permission to be included. Demonstration programs show time and again that participation rates are far higher when patients are enrolled by default and must actively opt-out. My prediction is that the NHIN will also be implemented as an opt-out, as opposed to opt-in, program.

In the abstract, health information exchange among hospitals and physician practices is a good thing. Potential benefits include: enhanced patient safety; faster, more accurate electronic delivery of laboratory results; fewer duplicate laboratory and diagnostic tests; and fewer unnecessary ambulatory visits, call-backs, and follow-ups.

But provider organizations can also get these and other benefits by voluntarily cooperating with each other, with the fully-informed consent of patients. Some organizations that own multiple hospitals or outpatient facilities already do this. We do not need government spending taxpayer money to build a nationwide network, and we certainly do not need the federal government potentially to have access to all of the private health information that such a network would contain.

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[1] 111th Congress, "American Recovery and Reinvestment Act of 2009"

[2] Department of Health and Human Services website: http://www.hhs.gov (NHIN Backgrounder)

February 28, 2009

Partial government control doesn't work, but more government control will?

By Jared Rhoads

Recently, a national organization of physicians released a report strongly criticizing the health reform effort in Massachusetts that imposes a mandate on residents to purchase health insurance.[1] Citing several studies and data sources, the group showed that the reform has added wasteful new layers of bureaucracy and has failed to control costs. The Massachusetts program, they said, is faltering badly and thus should not be held up as a national model for reform.

Not exactly a ringing endorsement of government intervention in health insurance, right?

Think again. The report was published by Physicians for a National Health Plan (PNHP), a group that exists specifically to advocate *for* a universal, comprehensive single-payer government system of healthcare in the United States. Since 1987, PNHP has sought a government-financed system that would eliminate private insurers altogether. The group is increasingly visible in the health policy world; with more than 15,000 members nationwide, it has rallied on the steps of the capitol, published papers in journals, and has lobbied Congress.

For PNHP, the reason that the Massachusetts reforms do not work is not because the reforms interfere with the health insurance market, but because they do not interfere *enough*. The state reform has failed, they argue, because it leaves too much of the private system in tact. Until residents are stripped of the ability to purchase coverage from private insurers, state agencies like Commonwealth Care cannot generate sufficient "administrative savings"—the magical ingredient in the group's Medicare-for-all vision that will allegedly lower the cost of healthcare and make additional entitlements possible.

In effect, PNHP denounces the Massachusetts reform in order to throw its support behind a much bigger goal: the United States National Health Care Act (H.R. 676). This act, which has already been introduced and referred to committee for review, would provide universal coverage under a single payer (the government) and promise all individuals the "best quality standard of care" for everything ranging from primary care and prevention to prescription drugs, mental health services, dental services, chiropractic services, podiatry, and more. According to the bill, this would all be made available for "free"—no co-payments, deductibles, or coinsurance required.[2]

In short, the approach that PNHP, the California Nurses Association, Healthcare for All, the American Medical Students Association, and dozens of other groups employ is: if one big dose of government doesn't work, try a bigger dose.

Combined with the recent statements by President Obama that healthcare reform "cannot wait ... and will not wait another year," it is becoming clear just how dangerous a time it is for those who value individual rights. Government payment for medical services—regardless of whether state or federal—is neither a moral nor practical solution to the problems we face in healthcare. But is anyone in the mainstream media arguing that point? Activists have no right to require the young to sacrifice the old, the healthy to sick, or the productive to the poor. But is anyone in Congress about to defend those convictions?

Contrary to what big-government activists maintain, market forces do work in healthcare. Insurance works—when policies are based on coverage that consumers actually want and when premiums are tied to actual risk profiles. New technologies lead to lower costs—when reimbursement rates reflect real prices. And uninsured individuals are not a menace to others—when providers are not forced to provide charity care and when states do not pick up the tab. Real markets feature competitors who are free to compete and consumers who are free to be discriminating in what they buy.[3]

Massachusetts has not had anything resembling a free market in healthcare for decades. But the answer is not to drift even closer to disaster and institute a bigger mess at the federal level. The answer is to unshackle consumers, providers, and insurers and free the markets once and for all.

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[1] "Massachusetts' Plan: A Failed Model for Health Care Reform" Physicians for a National Health Plan, February 18 2009

[2] The United States National Health Care Act, H.R. 676

[3] This is a careful improvement on a point made in Herzlinger, R. "Creating a Real Healthcare Market", *Boston Globe*, February 18 2009, a piece that unfortunately cedes ground to the antitrust camp.

January 17, 2009

Behind single-payer: administrative savings or healthcare rationing?

By Jared Rhoads

Many people seeking national healthcare reform—particularly those on the political left—believe that the United States should adopt a single-payer insurance system, similar to that of Canada. Proponents say that single-payer systems achieve lower per capita healthcare expenditures because they eliminate "wasteful and unnecessary" business practices such as advertising and screening of new applicants, and that this lowers administrative costs. By empowering the government to pay all health insurance claims, they say, we could simplify paperwork, standardize billing procedures, and consolidate many other activities entailed in processing claims. In other words, if we would just leave the business of health insurance to the government, we could get the same great care we have always had, except at a much lower cost.

But do single-payer systems really achieve lower expenditures through operational efficiency, or is something else going on in this picture?

At first glance, the argument regarding administrative costs may seem plausible. After all, businesses are always trying to reduce costs by building economies of scale, so what could be more economical than having one payer for the entire nation? And statistics do show that per capital spending on healthcare is lower in many countries with single-payer systems. For example, in 2005, Americans on average spent $6,401 on healthcare, versus $3,326 for Canadians—a difference of over three thousand dollars per person per year.

What pundits and politicians fail to disclose is that the reduction in administrative costs by and large does not account for this difference. In fact, it doesn't even account for most of the difference. According to an article in the *New England Journal of Medicine*, administrative costs totaled an estimated $1,059 per person annually in the United States versus just $307 per person in Canada.[1] That's a difference of just $752, or about 23 percent of the difference. Where does the rest of the alleged savings come from?

In effect, Canada's relatively low per capita rate of expenditure comes not from reducing paperwork, but from using the financial grip of the government to withhold care.

Consider how the Canadian system works. Canada uses a global budget system in which government officials dictate to hospitals how much they will be allowed to spend in a given year. Looking at variables such as patient volume, supply costs, and inflation,

they come up with a projection—i.e., a wild guess—for how much it will cost to treat all of the patients who come for care. Each hospital receives a lump-sum payment (or is put on a schedule of recurring payments), an amount of money that must last until the next round of guessing and granting.

When the money runs out, as it predictably does each time, care slows to a crawl. In order to defer or reduced costs, hospitals put patients on long waiting lists or substitute lower quality services (e.g., giving X-rays or ultrasounds in lieu of higher-resolution but more expensive MRI scans). In short, if you are a patient in Canada and need an expensive procedure, you had better hope that the facility is either early in its budget cycle and therefore still awash in money, or that it has deprived enough other patients the services that they need so there is still a ration left for you.

One of the most the perverse things about any socialized system of healthcare, including Canada's, is that the less the system does for its patients, the better its financial performance looks on paper. For instance, if a hospital withholds care from a patient long enough, the patient may give up and travel over the border to get their diagnostic test, surgery, or other procedure done elsewhere. In terms of the hospital's pocketbook (and therefore also the nation's pocketbook), this scenario goes down as an unseen and unaccounted-for personal expense, not an expenditure. Or, perhaps the patient on a six-month waiting list for hip surgery simply dies while waiting. In that scenario, there is no cost to the system at all.

Whatever the case, national expenditure figures of single-payer systems can be set as low as government officials desire, because what ultimately determines how much care patients receive is what the government is willing to fund—not how much patients want to spend or how much their physicians recommend they spend. (And even if patients wanted to pay out of their pocket for faster or better care by their own doctor, in many cases it is illegal to do so.) Quality and access to care can always be sacrificed to create the illusion of a government-run system that is low-cost and efficient because they are much more difficult to measure and compare.

The notion of administrative efficiency as the primary source of savings is nothing but a shabby cover story to hide the rationing inherent in a single-payer system. Most people wouldn't trust (or allow) a government official to set a budget for what they spend on dry cleaning in a year, yet with a little rhetoric and some confusing statistics, they are willing to hand over control of their own healthcare. Rather than emulating our neighbors to the north and instituting a top-down, centralized system in which the government makes decisions about how much care each person should get, Americans ought to demand the freedom to pay for as many or as few services as they desire, and to keep for themselves whatever they do not spend.

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[1] Woolhandler, Campbell, and Himmelstein. "Costs of Health Care Administration in the United States and Canada" N Engl J Med 2003;349(25):2461.

November 30, 2008

An opportunity for the pharmaceutical industry to defend itself

By Jared Rhoads

According to a recent article in the *Washington Times*, the nation's largest and most influential lobbying group for the pharmaceutical industry is preparing to launch a multi-million dollar public relations campaign to trumpet the benefits of markets in healthcare. The intent of the campaign, confirmed by the Pharmaceutical Research and Manufacturers of America (PhRMA) group, is to preempt an expected push by the Obama administration for price controls on prescription drugs.[1]

The group's concern over the political desire for new controls is certainly justified. During the presidential campaign, Obama promised to “take on the drug and insurance companies and hold them accountable for the prices they charge and the harm they cause.”[2] He also promised to “tell the pharmaceutical companies thanks, but no thanks, for the overpriced drugs.” Central to these price reforms is a plan to allow the federal government to “negotiate” (i.e., dictate) to pay lower prices for prescription drugs for Medicare enrollees. Such a move would have major implications. Medicare is not just any payer; it is the largest single payer of healthcare services in the United States. According to some estimates, the hit on revenues for pharmaceutical companies would be between $10 billion and $30 billion. That is about equivalent to wiping out the entire annual revenue of Merck, the third largest drugmaker in the nation.

But does PhRMA really have the fortitude to run an effective ad campaign in support of free markets? In the past, the group has taken some pro-market stances on issues involving intellectual property rights, regulatory barriers, and e-pedigree requirements. But the group has also been a vocal supporter of government-supported research, post-market surveillance requirements, SCHIP expansion, and worst of all, the 2006 Medicare Prescription Drug Benefit—the largest new entitlement program since the inception of Medicare in the 1960s. And if recent comments by PhRMA representatives are any indicator, then the group views the fight against price controls as more akin to “moving the pieces on the chess board” (i.e., manipulating members of Congress) than an opportunity to make a strong, philosophical case for free-market reforms.[3]

If PhRMA is serious about defending the free market, here is some advice:

1) Don't allow opponents to claim that the market has failed. Seemingly every discourse on healthcare begins with a harangue about how Americans spend more on healthcare and allegedly get less, and how the U.S. is the only industrialized nation that does not provides universal healthcare to its citizens. As a result, many people are led

to believe that the cause of our problems is too much privatization and not enough government. The reality is precisely the opposite: it is the policies, controls, and interventions of government that raise costs, divert investment capital, and thwart innovation. PhRMA's campaign needs to remind (or educate) the public that the pharmaceutical industry today is not a free market but a thoroughly hampered one, and that the only "change we can believe in" is change in the direction of a free market. The problem is not that markets have failed; markets haven't even been given a chance.

2) Name your principles. Proponents of price controls on prescription drugs can offer no rational objection to the argument that individuals have the right to produce and offer their products on whatever terms they wish. Unfortunately, in today's pragmatism-dominated environment, principles do not get the respect they deserve. A principled, rights-based argument alone will not silence those who are pushing for price controls, so PhRMA *should* tout the practical and economic case for free markets as clearly as possible. But please, PhRMA: anchor your message in the principle of rights, and refer to it at every opportunity. This is what will sustain the fight over the long run.

3) Demonstrate some integrity. Don't ask for laissez-faire treatment one minute, and demand increased subsidies, research grants, or bailouts the next. Yes, a mixed economy is a system of contradictions—and in the midst of oppressive regulations, taxes, and fees, no organization reasonably can be blamed for exerting their influence in Washington as a matter of self-defense. But to the fullest extent possible, PhRMA should be willing to explore ideas that trade today's goodies for increased freedom. With an incoming administration that will be looking for ways to control spending in the current economic crisis, 2009 will be a favorable time for new ideas. For instance, the pharmaceutical industry could offer to negotiate a 50 percent reduction in its share of NIH extramural research grants in exchange for a 50 percent reduction in the time or paperwork required for drug approvals. Or the same, in exchange for the lifting of liability on developmental drugs. Or for the removal of restrictions on advertising. Yes, it is a shame that your industry must "buy back" its own freedom—but that is one of the consequences of having failed to defend it properly in the first place. As for the forgone grant money, you won't miss it. Not when you realize the wealth of innovations and discoveries that your minds are capable of producing when left free to think.

As PhRMA begins to launch its campaign for the defense of free markets, advocates of laissez-faire will be watching—and hoping—for a confident and principled approach. If executed properly, it could be effective in stemming the tide of new price controls. If botched, it will be worse than offering no defense at all.

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[1] Lengell, S. "Drugmaker ads to target Obama idea" *Washington Times*, November 14 2008

[2] "Remarks in Newport News, Virginia" Barack Obama, October 4 2008. (This sentiment, by the way, was to a large extent shared by Obama's Republican opponent John McCain.)

[3] (Lengell, November 14 2008)

October 15, 2008

Healthcare in the 2008 Presidential election

By Jared Rhoads

For voters in search of a candidate who will consistently defend individual rights, free markets, and advocate minimal government, there is no excitement in the choice of Senator John McCain or Barack Obama for president of the United States. As some cultural commentators have shown, the two candidates are nearly indistinguishable in terms of their fundamentals beliefs and guiding principles.[1] Both believe that it is proper for the government to regulate the voluntary actions of its citizens, to engineer society according to certain environmental and cultural "values," and to confiscate whatever property it needs whenever it needs to in order to carry out these goals.

Naturally, the traditional media places at them opposite ends of the increasingly meaningless left-right political spectrum, despite their fundamental similarities. For starters, McCain and Obama differ not over whether to regulate entire industries but how; they differ not over whether to increase taxes but where the income-level breakpoints should be.

And on it goes for most issues, with the possible exception of one issue: health reform.

On the topic of healthcare, McCain and Obama actually are more different than they are alike—at least in rhetoric. Obama believes that healthcare is a birth right, and is willing to mandate employer-based coverage, increase insurance regulation, establish a standard minimum benefits package, and subsidize coverage for protected political groups to ensure this "right."[2] Yes, it is Obama—allegedly the candidate for change in this election—who advocates more of the same programs and interventionist policies that have assailed us every twenty years or so, reaching back to the 1940s (employer-based coverage), 1960s (Medicare/Medicaid), and 1980s (DRGs and CONs).

McCain, on the other hand, at least says he will consider reforms that would not violate individual rights. In the September/October issue of *Contingencies*, an actuarial journal published by the American Academy of Actuaries, McCain even mentions freedom[3]:

> *I offer a genuinely American vision for health care reform that preserves the most essential value of our lives—freedom.*

In fact, he uses it several times in the article:

> *We believe in the pursuit of personal, political, and economic freedom for everyone. My vision expects and encourages free people to voluntarily unite, but*

they cannot be compelled to do so under the principles of limited government that best protect our individual freedom.

Some of this rhetoric is supported with pro-market plans, such as his pledge to replace the employer-based tax credit for healthcare expenditures with a personal tax credit, and his pledge to open up the insurance market for cross-state competition. Would these changes be positive? Yes. Will these changes ever be more than promises? Given McCain's inability to diagnose the correct ailment (government), voters can only speculate.[4]

McCain is better than Obama on healthcare, but healthcare is just one of several important issues this election. A good idea here or there on healthcare is something to consider—especially if you or a loved one are reaching an age where you will be relying more on the availability and quality of such services—but it is by no means the only criterion to consider. Ultimately, it is up to each voter to decide what the most important issues are, and either vote or abstain accordingly.

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[1] Biddle, Craig. "McBama vs. America" *The Objective Standard*. 3:3 (Fall 2008)

[2] Second televised debate between Sen. Barack Obama and Sen. John McCain; Commission on Presidential Debates, October 7 2008. During the debate, Sen. Obama said "I believe that health care is a right for every American."

[3] McCain, J. "Better Care at Lower Cost for Every American" *Contingencies*. Sep/Oct 2008, 29-31

[4] Like many individuals in both parties, McCain identifies the fundamental problem of the U.S. healthcare system as "high costs," as if high costs are a cause rather than an effect. The high cost of healthcare is one of the most obvious symptoms that something is wrong in healthcare, but it is not the root cause.

July 30, 2008

McCain is right about ending employer-based insurance, but he won't win

By Jared Rhoads

The *Wall Street Journal* today published an opinion piece by John C. Goodman of the National Center for Policy Analysis on the virtues of John McCain's plan for health reform. The article, entitled "McCain Is the Radical on Health Reform," describes McCain's plan as one of sweeping, market-based change, and does so with a certain amount of success.[1] But just as it is proper to give credit where credit is due, it is also important to consider what the plan calls for as a whole, and how realistic it is that the good aspects of the plan would ever actually be signed into law.

Goodman's analysis of the current way in which health insurance is purchased is spot-on: employer-based tax deductions are arbitrary, senseless, and they result in distorted market incentives and unfair exclusions for part-time workers and self-employed individuals. The main virtue of the McCain plan is that it would break this link, enabling wages and compensation to rise and allowing individuals to purchase to purchase private insurance of their choice with pre-tax dollars. Add to this the freedom for individuals to purchase insurance across state lines—which, to his credit, McCain does support—and yes, Americans would have for the first time in decades something vaguely resembling a free market in the area of health insurance. Many reforms would still be needed to get the full benefits of capitalism, but greater freedom in these two areas would in fact gradually lead to better, more affordable insurance for consumers.

Congress, however, may be already too enamored with the idea of universal care to allow the best aspects of McCain's plan ever to become law. At this point, it is difficult to gauge how much Constitutional spirit is left in Washington. But even if the plan were to pass, its many shortcomings could largely negate its positive aspects.

For one, although McCain says his plan would not raise taxes, his plan does not call for taxes to be lowered, either. Massive amounts of taxpayer money would still be funneled into health and wellness programs, "public health infrastructure," and government programs to convince people not to smoke.[2] A Guaranteed Access Plan, in which subsidized insurance would be provided to people rejected by commercial insurers due to preexisting medical conditions, is another cornerstone of his plan for health reform.[3] Senator McCain also goes out of his way to stress so-called common-sense initiatives, including early intervention programs and earmarks for preventative care and the promotion of "healthy habits"—habits which, presumably, would be defined by government experts.[4]

Nothing is said about the rights of doctors, the productive men and women who make advanced medical services possible.

As his positions on other issues reveal (e.g., mandatory community service, new business regulations), John McCain is no great maverick and no great supporter of rational egoism or free markets. His plan for dismantling employer-based insurance would be a step in the right direction, and it *is* a good sign for the culture that pro-market commentators such as John C. Goodman are invited to say this in the pages of the Wall Street Journal. But with vagaries and concessions galore, this so-called Republican alternative to outright socialized medicine is yet another "reform" that is difficult to get very excited about.

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[1] Goodman, John C. "McCain Is the Radical on Health Reform" Wall Street Journal, July 30 2008

[2] "Straight Talk on Health System Reform" Official John McCain Candidate Website, Accessed July 30 2008

[3] Ibid., "John McCain Will Work With States To Establish A Guaranteed Access Plan"

[4] Ibid., "John McCain Proposes A Number of Initiatives That Can Lower Health Care Costs"

October 31, 2007

How much countries spend on healthcare is not of fundamental importance

By Jared Rhoads

A recent article in the health policy literature asks, “What should a country spend on healthcare?”[1] The author notes the wide range in per capita health expenditures around the globe, and wonders whether any of the approaches commonly used to address this question can determine a “correct” level of spending. Some researchers, for example, rely on a peer approach, in which they investigate how much similar countries spend on their health. Others analyze the question in terms of political economy, the production function, or the budgeting process. Ultimately, the results of these studies end up in the public policy arena and reports published by the United Nations and World Health Organization.

This dilemma could only exist under a heavily government-influenced system. Under capitalism, individuals consume goods and service in accordance with their own means, needs, and desires, to the maximization of their overall happiness and well-being. If an individual deems it desirable to spend more on his health or the health of someone he values, then he makes that investment independent of what others think.

As a matter of economizing, nobody—researchers and politicians included—can be closer to each decision or have better information than the individual. As a matter of political rights, no justification can be given for inserting the state between Economic Man and his doctor. On what basis, then, can anyone prescribe how much to spend?

In a free society—or even in a society in which the government were to interfere with healthcare substantially less than it currently does—there would be no need for such a discussion. Consider any semi-free market such as consumer electronics, books, or travel. There is no great controversy over whether individuals spend too much or too little on televisions, are reading wastefully, or are taking too many vacations. People manage these consumption decisions without the help of the government. This is true for even essentials such as food and clothing, and healthcare would be no different.

The high cost of healthcare in the U.S. *is* a problem, but debating aggregate expenditure levels is a distraction. Government should focus on protecting the rights of individuals to purchase the medical services they see fit, not making decisions for us.

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[1] Savedoff, W. What should a country spend on healthcare? *Health Affairs*. 26, no. 4 (2007): 962-970

March 26, 2007

Let people pay organ donors

By Jared Rhoads

In a March 16th commentary in the *Wall Street Journal*, Sally Satel praises the Charlie W. Norwood Living Organ Donation Act, which makes paired organ exchanges legal where they were effectively illegal before.[1] Paired matches enable patients who have willing but biologically incompatible donors to trade donors, and thereby avoid the long waiting list. It has been estimated that this approach could make between 6,000 and 6,500 more kidney transplants possible in the U.S. each year.[2]

The Norwood Act is exactly the type of creative, win-win solution that donors and their families would have arrived at decades ago had they been free to engage in simple bartering. It is a welcome improvement to the current, but it does not go far enough. As a mere "clarification" of the National Organ Transplant Act, the Norwood Act fails on two accounts: 1) it does not challenge the premise that government is justified in preventing these voluntary transactions in the first place, and 2) it distracts policymakers from having to address the fact that a free market for organs would save even more lives.

The current waiting list system is essentially a rationing mechanism. It does nothing to increase the overall supply of the good in demand (e.g., kidneys); it only dictates the order in which people receive them. Bartering, by comparison, increases the supply available for exchange by bringing new people in the donor pool who otherwise would not have had a reason to donate. This increase, however, is still relatively small because for a successful exchange to be arranged, there must exist a perfect match (i.e., what economists term a "double coincidence of wants"). Finding such a match comes at a significant cost. This is why people invented money—a finely divisible, commonly-accepted medium of exchange that makes every participant a potential buyer or seller.

Early societies discovered the superior efficiency of monetary exchange over barter exchange long ago. The lives of countless more transplant candidates could be saved if only our legislators could catch up, so to speak, and let markets work.

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[1] Satel, S., "Doing Well By Doing Good," Wall Street Journal, March 16 2007

[2] Paired matches by living donors are not specifically prohibited by law, but the language of the 1984 National Organ Transplant Act (which makes it a felony to give or receive something of value in exchange for an organ) is so broad that hospital administrators generally do not allow them.

December 1, 2006

Doctors are ill-equipped to defend themselves

By Jared Rhoads

Last month, the *Boston Globe* published an op-ed written by two medical doctors which attempted to establish a dichotomy between two possible policy options: the individual mandate and the single-payer national health insurance program.[1]

The first approach, which was made law in Massachusetts and will be instituted in July of 2007, forces uninsured and underinsured residents to purchase additional coverage. This coverage is highly subsidized by the state (i.e., by taxpayers), despite being marketed as a solution encouraging individual responsibility. The other approach is the system that has been instituted in Australia and Canada, in which the federal government finances universal health insurance. This approach is championed by the authors of the op-ed, who make no attempt to hide the ultimate source of the financing: "The program would be funded by an increase in taxes." As they put it, "[The new system] would be an improved and expanded version of Medicare."

Although the second proposal is far worse than the first, the differences are, in a sense, superficial. Both options use force, and both involve redistributions of income. In a different era, both would have been publicly exposed as futile and statist by the great identification of French enlightenment economist Frederic Bastiat: "The state is a great fiction by which everybody tries to live at the expense of everybody else."

Philosophically, what allows such utopian proposals as single-payer national health insurance to gain a following in the profession is the unfortunate fact that today's doctors are ill-equipped to defend themselves against calls for self-sacrifice. As medical students, these doctors are told, and many believe, that the only proper motive for entering medicine is to help other people—not intellectual challenge, love of the field, or to earn a good living. In other words, doctors are told they must be altruistic and self-sacrificial.

The guilt that this false theory of morality inculcates is a powerful psychological tool. It is exactly what advocates of state-run medicine need in order to attract the new breed of doctor necessary for their grand vision: the 9-to-5 bureaucrat physician who would rather practice medicine out of a government manual and treat "the public" than think for himself and treat individuals.

Government-funded medicine means government-controlled medicine; it is a fact of political economy.[2] To see doctors welcome these programs not reluctantly or hesitatingly, but *willingly*, is chilling.

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[1] Hochman and Woolhandler, “Healthy Skepticism,” Boston Globe, October 28 2006

[2] Feldstein, P.J. Health Policy Issues: An Economic Perspective Health Administration Press. Chicago IL. Third Edition, 2003

October 12, 2006

Technology is not the problem in America's battle with healthcare spending

By Jared Rhoads

In a recent *New York Times* article, Tyler Cowen, professor of economics at George Mason University, argued that the American healthcare system may be performing better than it appears.[1] It is usually taken that the American healthcare system is a failure, because the United States spends a greater portion of its gross domestic product on medical care than any other nation and still cannot boast a life expectancy superior to that of many other nations. Cowen warns not to conclude that these expenditures are therefore wasted altogether. For instance, they fund the discovery of new drugs and the development of medical innovations. And, as Cowen points out, fifteen of twenty-two (68 percent) Nobel Prizes in Medicine over the past ten years have gone to researchers either born or living in the United States. Some value does get created. After all, $1.88 trillion (the most recent National Health Expenditure figure available) would be difficult to squander completely.[2]

Cowen goes on to make the bold—and true—observation that American-funded medical innovation improves health and life expectancy in all wealthy countries, not just the United States. This is one of the numerous positive effects of a relatively free flow of trade and innovation. This flow of trade benefits everyone involved, but is rarely acknowledged in statistics that compare one country to another. Cowen correctly concludes that a move toward a European-style national healthcare system as a reaction against rising costs would be hasty, and would harm both the health of the United States and that of Western Europe.

A further point about the relationship between technology and expenditures, however, needs to be emphasized: in a market economy, new technology per se does not increase the cost of goods and services at all. New technology *decreases* costs. Thus, it is one thing to view technological leadership and Nobel Prizes as some silver lining or consolation prize for suffering the nation's astronomical health expenditures. It is an entirely different thing to defend the advances of technology as an unmitigated good—and an ally, not a foe, in keeping costs low.

Technology, by definition, is a new manner of accomplishing a task. A person uses one technology over another because it provides a gain in productivity: either to get more output out of the same input of time and resources, or the same output with less input. For instance, a doctor using an electronic medical record may be either see more patients in a day, or see the same number of patients in fewer hours. Both are gains in productivity driven by technology.

Technology can only be linked to a rise in expenditures if the demand for it outpaces the gain in productivity. But what would cause demand to be raised to this artificial level? In the United States, government expenditures on healthcare—essentially Medicare and Medicaid—account for over 45 percent of total expenditures.[3] These programs, which send the medical bill to "society" rather than the person who uses the services, in effect send demand for such services surging. When other people ultimately pay for the choices you make about the care and services you are going to receive, the sky is the limit as far as you are concerned.

In terms of government cost management, the $2 pill that prevents a visit to the emergency room is a cost-saving technology. But the expensive PET scan that detects brain abnormalities in a patient and allows him to undergo therapies to possibly save his life, is a foe. If the PET scan did not exist, then the disease may have gone undetected, and the patient may have died at home, costing "the system" zero dollars. From the government's perspective, the best-case scenario is for a person to have a long life of dutiful taxpaying, followed by a quick, costless death.

A sovereign patient still faces a tradeoff decision, but he is allowed to weigh for himself the costs of receiving such a scan against the potential benefits. Under capitalism, it is the patient's choice. Under a government-run healthcare system, any procedure can be forcefully withheld on the grounds that it takes too many dollars away from the fund that must also serve other patients. As University of California (Irvine) economics professor Paul Feldstein writes[4]:

> *The inevitable consequence of a free medical system is a government-imposed expenditure limit. Although physicians would still be responsible for determining who would receive care and for which diagnoses, "too little" care would likely be provided; this occurs in government-controlled health systems such as in Canada and Great Britain. Queues are established to ration the available medical care, and waiting times and age become criteria for allocating the available medical resources.*

Whether in a market system or a government-run system, *someone* has to make a decision about the tradeoff between cost and benefit. In the former case, the patient makes the decision for himself. In the latter, the government decides.

In a market-based healthcare system, breakthroughs in medical technology are treated as gains in productivity and expansions of treatment options to the patient. In a government-run healthcare system, breakthroughs in medical technology—particularly those that add to the patient's array of treatment options or require substantial up-front investment on the part of the provider—are treated as a contributor to the crisis of "runaway costs."[5] Thomas Sowell makes the final link[6]:

> *Perhaps the simplest rationale for expansion of the areas and powers of governmental decision-making is that a crisis has thrust new responsibilities*

> *upon the government, and it would be derelict in its duty if it did not expand its power to meet them. Among the more prominent ideological rationales for expanded government is a 'maldistribution' of status, rights, or benefits....*

We should praise medical technology for the ways in which it can enhance our lives, not blame it for our policy failures.

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[1] Cowen, T. "Poor U.S. Scores in Health Care Don't Measure Nobels and Innovation." *New York Times*, October 5 2006

[2] Office of the Actuary, Centers for Medicare and Medicaid Services. National Health Expenditure Data, 2004.

[3] Ibid.

[4] Feldstein, P.J. *Health Policy Issues: An Economic Perspective*. Health Administration Press, Chicago IL. Third Edition, 2003. 15

[5] Lamm, R.D. "High-tech health care and society's ability to pay." *Healthcare Financial Management*, September 1990

[6] Sowell, T. *Knowledge and Decisions*. Basic Books. New York. 1996. 326

August 4, 2006

Cuban healthcare is no model for the United States

By Jared Rhoads

Glowing appraisals of Cuba's state-run healthcare system are plentiful in the health policy literature. For instance, it is claimed that, from the post-revolutionary decade (1959-1970) through the 1980s and beyond, Cuba has achieved consistently outstanding health indicators across the board.[1] Cuba's infant mortality rate is said to equal that of industrializes nations. Cuban life expectancy allegedly exceeds that of Americans. And at 1 doctor for every 297 inhabitants, Cuba is reported to have one of the highest rates of doctors per capita in the world.[2] Researchers even enthusiastically note the practice of foreigners flocking to Havana for treatment as "medical-tourists."[3]

The projected image is that of a country where the state of medicine is not only more advanced, but less expensive. Is this true?

Such statistical claims would normally either require a detailed review of the researchers methodologies or a new round of data collection in order to be soundly refuted. But why believe that self-reported figures from a dictatorship are credible at all? In Cuba, truth and reliability in such figures is seriously doubtful, and in any case certainly not deserving of any outsider's blind trust. What subordinate party-member would willingly hand Castro an annual report portraying anything less than stellar performance? Under communism, loyalty to the party is the only course of action that has any survival value, since the standard of truth is whatever the men of power desire. All dictators have this problem: Hitler, Stalin, Pol Pot, Saddam Hussein. And Fidel Castro, too. As a subordinate, the only way to keep one's position, one's livelihood, and ultimately one's life, is to say what one's superiors want to hear.

Those who look at Cuba and see a utopian healthcare system are engaged in a similar evasion. For years, billions of dollars of annual subsidies from the U.S.S.R. helped prop up and make passable a national healthcare system in Cuba.[4] When those subsidies disappeared, the healthcare system that the communists had dreamed of became even less feasible. The quality of care available to the average citizen deteriorated, facilities became dilapidated, and equipment quickly became outdated.[5] A general shortage of nurses, assistants, and midwives developed, and had it not been for the exemption of medicines and medical supplies from the U.S. embargo[6], quantities of those resources would have been practically nonexistent as well (as it is, they are meager). Rather than becoming streamlined and eliminating "wasteful" competition, the Ministry of Public Health ballooned to the point of having the highest overhead costs in the world.[7]

Many researchers in public health praise Cuba for its equality, yet its two-tiered system is even more pronounced than that of other nations. In a market economy, economic demand for care is controlled by graduated price levels. Mechanisms such as price discrimination lower the average cost of healthcare for everyone by charging the rich more for incrementally better or newly-available high-tech services. Both classes of consumers benefit. In Cuba, however, access to care—at least the good care that researchers so frequently cite—is dispensed according to political power. Sometimes dubbed "medical apartheid," Cuban Communist Party officials and those who can pay in hard currency (which is where the medical tourists from richer, freer nations enter the picture) can get first-rate medical services any time they want. Cubans without party credentials receive the squalid quality care that is leftover, in facilities kept separate from the modern, clean ones.

Idealists for Communism and Socialism complain that economic and social organization based on private property does not sufficiently consider the interests of all members of society—that such systems serve only the purposes of a "single strata" (i.e., those who earn their wealth freely through trade and cooperation).[8] Instead, Cuba has created a political proletariat and bourgeoisie, which has taken down their healthcare industry along with everything else.

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[1] De Vos, P. "No one left abandoned: Cuba's national health system since the 1959 revolution." Int J Health Serv. 2005;35(1):189-207

[2] Benjamin M, and Haendel M."Cuba. A healthy revolution?" 1991 Fall;8(3):3-6

[3] Charatan, F. "Foreigners Flock to Cuba for Medical Care" West J Med. 2001 August; 175(2): 81

[4] Cuban American National Foundation. "Health Care in Cuba: Myth Versus Reality." Cuba Issue Brief. See also Section 1705 of the Cuban Democracy Act of 1992

[5] (Charatan, 2001)

[6] "An overview of the Cuban Assets Control Regulations Title 31 Part 515 of the U.S. Code of Federal Regulations." U.S. Department of the Treasury Office of Foreign Assets Control. 1999

[7] Alonso, J., R. Donate-Armada, and A. Lago. 1994. "A First Approximation Design of the Social Safety Net for a Democratic Cuba." Cuba in Transition. 4. Washington, D.C.: Association for the Study of the Cuban Economy (ASCE)

[8] Mises, Ludwig von. *Socialism: An Economic and Sociological Analysis*. Yale University Press. 1951. 16

February 19, 2006

Healthcare rationing, Canadian-style

By Jared Rhoads

In the Canadian province of Quebec, it is technically illegal for patients to purchase private health insurance or pay for private medical procedures. Quebecers pay into the public health system and take the treatment the system hands out, whenever it can manage to hand it out. This latter variable—the variable of time—is the subject of a new legislative proposal released by Premier Jean Charest and Health Minister Philippe Couillard.

The issue is that of waiting in lines. In Canada, the demand for medical services far outstrips the abilities of its doctors to supply those services. It has to. With comprehensive care literally guaranteed by the government, demand is, in effect, infinite[1]. But while such grandiose promises can always be offered on the demand side, the solution of supply cannot be faked. Supply entails real equipment, real facilities, real medications, and real doctors. When demand exceeds supply and prices are not allowed to rise, the result is a shortage. And a shortage means waiting. And waiting.

(In a study quoted in the *Wall Street Journal*, The Fraser Institute, a Vancouver think tank, calculated that in 2003 the average waiting time from referral by a general practitioner to actual treatment was more than four months. Other waiting times from the same study: two months for post-surgery radiation therapy; three months for an MRI; a year for neurosurgery. Across all cases, the average waiting time from referral by a general practitioner to actual treatment is more than four months.)

Charest and Couillard's proposal guarantees that, for certain procedures such as knee and hip replacements and cataract operations, Quebecers will no longer have to wait more than six months. If a patient does have to wait for more than six months, then the province will pay for the procedure to be done by a private doctor. And if the patient has to wait for more than nine months, then the province will pay for the procedure to be done outside of the province or even outside of the country. They say their proposal will mark the beginning of "a new era for health care in Quebec."

I hope the people of Quebec are prepared for a budget crisis.

Previously, keeping people waiting in lines was the one way in which the government *could* achieve the effect of cost control. It could offer "unlimited" care because it could fulfill this promise at whatever pace it chose (i.e., a very slow one). It limited the demand it met by limiting the supply of doctors, nurses, operating rooms, and MRI machines. Want to reduce outpatient expenditures by 29 percent? Easy: just shut down medical

centers for the weekend (thereby eliminating two-sevenths, or 29 percent, of the work week).

Allowing patients to send the bill to the government for receiving medical services in other countries will decrease *some* waiting times, but it will do so at tremendous expense. The government could control its costs (dishonestly) by limiting the supply of services in Canada. They cannot, however, be controlled on the much larger world market, where Canada's freebie-fueled demand actually can be met by existing capacity.

To channel P.J. O'Rourke, when people get to see how expensive free and unlimited healthcare really is, will they still think their system works?

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[1] This creation of infinite demand is not to be confused with the rational sense in which man has a limitless need for wealth. The difference is that in the latter case, man seeks goods to the extent he is able and prepared to pay for them, i.e., to the extent that he has produced things with sufficient trade-value to be able to exchange for the goods and services he desires.

January 17, 2006

When it comes to health insurance, let's leave employers out of it

By Jared Rhoads

Again discount retailer Walmart is being punished for its success and blamed for government-created ills. Last week, the Maryland state legislature overturned the veto of Governor Robert Ehrlich and passed a bill that will require any employer in the state with more than 10,000 employees to spend a minimum of 8 percent of its payroll on healthcare—or else pay the state the difference. In effect, it applies to just Walmart. This is part of the AFL-CIO's "Fair Share Health Care Legislation" movement. Their claim is that by not giving all of its workers full health coverage, Walmart is somehow shifting a burden onto state handout programs.

That is grossly unfair. If Walmart disappeared tomorrow, and every employee had to find a new job, how many people does the AFL-CIO think would be able to get jobs with healthcare? Better than 47 percent, the percentage of Walmart employees that are currently covered? Not so easily. Mom-and-pop retailing is no panacea for getting people insured. It's not even a panacea for keeping people employed. Have Maryland taxpayers forgot how expensive unemployment compensation can be?

In its January 16th "Review and Outlook" piece, the *Wall Street Journal* properly calls this the return of HillaryCare.[1] In 1994, the author reminds us, one of the reasons that the Clinton healthcare plan failed was because of its unpopular employer mandate. The closing paragraph, especially the first sentence, is a gem:

> *What's really going on here is an attempt to pass the runaway burdens of the welfare state on to private American employers. As we're learning from Old Europe and General Motors, this is bad news for both business and workers in the long run. The U.S. doesn't need a revival of HillaryCare on the installment plan.*

Unfortunately, this type of legislature is now being discussed in other states, too.

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[1] "HillaryCare Returns," *Wall Street Journal*, January 16, 2005

January 13, 2006

Patients versus the new Medicare drug coverage benefit

By Jared Rhoads

Pharmaceutical companies used to offer patient assistance programs that would provide free or deeply discounted drugs to the elderly and the disabled. But with the new Medicare drug coverage benefit now in effect—the biggest Medicare expansion in Medicare's 40-year history—the federal government is forcefully taking over that role. Just thirteen days into the new year, many patients are already longing for the old days.

From the *Wall Street Journal*:

> *What is clear is that the new Medicare drug benefit, created to make prescription drugs more affordable for the elderly, is having the unintended effect of making it more expensive, or prohibitive, for some poor older Americans to get their medications. At least one million people who would have qualified for the industry programs make too much money to get any government assistance to help with the out-of-pocket costs under the new Medicare plan.*[1]

And that's to say nothing of the implementation failures. The *Philadelphia Inquirer*:

> *Many of the most vulnerable elderly and disabled patients have been unable to get medicine since the program's start on January 1. Calls for help to Pennsylvania's health insurance hotline have reached record levels, and several pharmacists said they had never seen greater chaos. [A Medicare spokesperson] said the agency had identified a computer glitch that caused several hundred thousand of the poorest recipients nationwide to be overcharged and thus they had to go without their drugs. The agency is working on the problem.*[2]

In policy planning and design, there is no such thing as a "side-effect." There are only effects, some of which are understood, and others which are ignored or evaded.

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[1] Levitz, J., Armstrong, D. "Low-Income Seniors Get Tangled In Unexpected Medicare Glitch." *Wall Street Journal*, January 13, 2006.

[2] Sullivan, J. "Medicare meltdown." *Philadelphia Inquirer*, January 12, 2006.

November 22, 2005

Price controls lead to shortages

By Jared Rhoads

Price controls lead to shortages. If there can be such a thing as a law of economics, then this would certainly qualify as one.

Recently, the *New York Times* reported that doctors are objecting to the planned cut in the reimbursements they are paid to see Medicare patients. A mathematical formula embedded in the Medicare law requires that fees be cut 4.4 percent for 2006. For doctors, who must accept whatever price the government sets for Medicare patients, the reduction amounts to a mandatory pay cut. Will the policy have the desired effect of making care more available and affordable for seniors? Of course it won't. Already, doctors are (rightly) planning to take on fewer Medicare patients next year. The price control is the cause and a shortage is the effect.

In fact, a recent survey by the American Medical Association shows that if the new rates take effect on January 1, then more than a third of physicians would decrease the number of new Medicare patients they accept. This is in addition to the general shortage of physicians that has been festering for the last two decades.

Why do price controls lead to shortages? It starts when the government foots the bill of a social welfare program such as Medicare. Demand for that goodie rises. When demand for that goodie rises, it costs more for the government to continue to offer that goodie. Eventually, the program exceeds its budge. In order to save the program, it becomes necessary to either spend more money or alter the way in which the goodie is offered. After all, he who pays the bill calls the shots. This has been the history of price intervention and the welfare state.

When the government calls the shots, the will of the bureaucrat overrides the judgment of your doctor. In the coming years of Medicare, expect procedures that were once covered to be dropped. Expect quality to worsen, as the best doctors move on to other areas of medicine. And when pay-for-performance arrives—the alleged "quality improvement" initiative where doctors' compensation is linked to the health of their patients—expect administrators to rig the pay rubric as a backdoor way of cutting costs.

In other words, expect a government-induced shortage in medical services. Your medical care will be free, of course, but the care won't consist of what you need, when you need, or how you need it. The price will be near zero (after taxes, that is), but its value to you will be zero.

November 13, 2005

So prescription drugs are now part of a federal entitlement

By Jared Rhoads

In his weekly radio address today, President Bush announced a new prescription drug benefit. Fed up—and apparently surprised—that unlimited free treatment costs money, Medicare apologists now want to subsidize preventative medicine in order to avert more expensive claims later on. Bush:

> *In the past, Medicare would pay tens of thousands of dollars for ulcer surgery, but not a few hundred dollars for prescription drugs that eliminate the cause of most ulcers. In the past, Medicare would pay more than $100,000 to treat the effects of a stroke, but not $1,000 per year for blood-thinning drugs that could have prevented the stroke in the first place.*

Before sponsored preventative medicine was conceived, people took precautions and people paid for their own medication. They engaged in these things all by themselves because if they did, they enjoyed good health, and if they did not, they risked illness, disease, and financial stress. The incentive was placed squarely on the shoulders of each individual, and voluntary charity took up the slack.

Now individuals will be sharing incentives with bureaucrats and Medicare administrators, whose job is to see that individuals do not take too much out of the collective pot of Medicare dollars. Washington will now decide which drugs and treatments are preventative enough to earn the subsidy.

So what will the selection criteria be? By government logic, there is no reason to limit the subsidization to just out-of-pocket prescription drug expenses. Why not outright pay seniors to take an aspirin a day or to enroll in cardio-fitness programs at their local gyms? Moreover, since health is a lifelong achievement, let us not be so short-range in our policymaking: perhaps we should round up smokers in their twenties and pay them a stipend to quit. Or, buy a new bicycle for every ten year-old in order to stave off obesity. (Ought purchases of the Sony Playstation and Microsoft X-Box carry with them punitive taxes, as has been done with cigarettes?) These measures *would* reduce future Medicare claims, after all.

“The days of low-income seniors having to make painful sacrifices to pay for their prescription drugs are now coming to an end,” Bush said. The days of compulsory support continue for everyone else.

November 1, 2005

End the guild system that is constraining the medical profession

By Jared Rhoads

Just as practicing capitalism in one country can make other countries richer, practicing socialism in one country can make other countries poorer. This holds true even if the resource in question is doctors, and even if the country playing the role of the socialist offender is the United States.

A new study published in the October 27th edition of the *New England Journal of Medicine* provides a look at this phenomenon by relating the U.S. shortage of doctors to the shortage of doctors abroad. Ideally, shining the spotlight on domestic policies would lead to the elimination (or foster self-correction) of the factors that cause the shortage. What we are more likely to get is a legislative proposal, which will give birth to a new program, which will waste money and make the situation worse.

But back to the shortage. U.S. medical schools graduate about 17,000 students each year, to fill about 22,000 first-year residency slots. At present, the number of new physicians each year barely equals the number of doctors retiring, and this will shift for the worse significantly when baby boom physicians who began their practices in the 1970s and 1980s begin to retire and become patients in need of medical services themselves.

To compensate for this shortage, the U.S. has become an importer of doctors from smaller, poorer countries such as South Africa, Ethiopia, Jamaica, Haiti, and Ghana—from which many fine doctors come, to be sure. But the U.S. imports not because these countries produce superior medical talent or because our hospitals choose to exercise their right to source globally to save costs. We import because it is all we can get. The result is compromised care at scarcity prices (i.e., higher prices).

The Ghana side of the equation is even worse. Ghana is down to just six doctors per 100,000 people, a direct result of years of losing its doctors. Three out of every ten doctors it educates move to either the U.S., Britain, Canada, or Australia—all of which have government policies that restrict the construction or licensing of medical schools in some way or another, and all of which have shortages. In a recent interview with a Ghana news service, one doctor from Ghana said, “I have at least nine hospitals that have no doctor at all, and 20 hospitals with only one doctor looking after a whole district of 80,000 to 120,000 people. Women in obstructed labor all too often suffer terrible complications or death for lack of an obstetrician.”

At root, the shortage is the result of the guild-like practice of groups who seek the backing of government to protect their immediate interests. For the past twenty-five years, the American Medical Association and other industry groups have managed to convince officials of an impending glut of doctors. They have lobbied to limit the number of new physicians by placing restrictions on enrollment in medical schools. Throughout, of course, their statistical “guesstimates” have always aligned with their agenda: in 1994, the Journal of the American Medical Association predicted a surplus of 165,000 doctors by 2000. They weren’t even close.

The guild system can rightly be linked with the socialist mentality because of the hostility to market-driven resource allocation and the reverence for centralized planning that is common to both. This is perpetrated under the guise of “ensuring economic security,” but whose health care system is secure now in the face of this artificial scarcity? The effect of the U.S. shortage is already taking its toll abroad. It will catch up to us shortly.

October 24, 2005

Antitrust laws do not make any sense in healthcare either

By Jared Rhoads

Five years ago, two hospital operators in northeastern Illinois—Evanston Northwestern Healthcare and Highland Park Hospital—merged. And they flourished. Evanston upgraded its facilities and in just four years made more than $120 million in improvements to the Highland Park facility. They were the first to bring a heart program and a coordinated cancer-care program to their county. And earlier this year, their president Ronald Spaeth won the American College of Healthcare Executives' 2005 Gold Medal Award, the independent organization's highest honor.

But last Monday, in a typical government-style recognition of achievement, Chief Administrative Law Judge Stephen J. McGuire ordered Evanston-Highland to split, claiming that the 2000 merger "substantially lessened competition" and that there is a "reasonable probability" that further "harm [to] consumer welfare" will occur in the future. They have 180 days to comply.

The anti-competitive harm to which Judge McGuire referred was Evanston-Highland's price increases. Shortly after the merger in 2000, the regenerated company raised prices for many of its services. According to reports, the increases were "50 percent or more in certain instances, and in one case of inpatient care, as much as 200 percent."

If you are still waiting for a description of an actual crime, then you are going to be disappointed. That's because the hospital's price increase *was* its crime, as charged by the Federal Trade Commission and the Department of Justice, and as provided for under antitrust law. Never mind that this is an industry in which costs have been rising for decades. To repeat, their new pricing menu was the crime, not any sort of negligence, fraud, or violation of contract.

Under this notion of antitrust law, a price is not defined as the amount of money or goods at which two parties voluntarily agree to make a transaction. Rather, a price becomes "the extent to which a consumer feels he is being exploited by a producer." In 1986, when Judge Richard Posner upheld the Federal Trade Commission challenge to a similar hospital merger, he explained that the "ultimate issue" in the antitrust review of mergers is "whether the challenged acquisition is likely to hurt consumers, as by making it easier for firms to collude, expressly or tacitly, and thereby force price above or farther above the competitive level." That flaky bit of reasoning is presumably the legal standard by which the latest Chicago case was also judged.

Jared Rhoads writes and speaks about a variety of issues in healthcare and health policy. By day he works as a senior research specialist in the global healthcare division of a large consulting firm. The views expressed in this book are those of the author, and do not necessarily reflect the views of Mr. Rhoads's employer.

You can find more writings and commentary at jaredrhoads.com.

Cover photo by Jared Rhoads