

A Proposal for National Health Care

Debate about the health care system—particularly debate about what the government should do—is an odd mixture of humanitarian sentiment, talk of rights and justice, and worry about money. From this debate emerge these desiderata for any national health care plan: it should promote fairness to suffering individuals of all incomes, recognize differences in individual preferences and needs, and reduce escalating medical costs. Here one leading proposal to meet these desiderata is defended.

Fairness in Health Care

All nations permit some inequality in the distribution of goods. But inequality in health care is commonly regarded as a particularly severe inequality for those at the short end of it. Thus, every advanced Western nation has taken measures in the direction of equalizing access to health care among its citizens.

It is easy to understand why this should be so. With regard to economic inequality in general, persons may disagree about what real poverty is and how bad is really bad. One can adjust, one might say, to a given level of income, and learn to want nothing more. By contrast, it is less plausible to talk about adjusting to pain, disability, or imminent death. These are objective misfortunes, misfortunes for everyone. For these reasons, a modicum of health care has come to be regarded as part of the decent minimum that society must provide for its members.

Then, too, equality in health care seems to follow from the notion of equality of opportunity. That notion requires that everyone have an equal chance to attain a better place in society on the basis of merit. Effective health care maintains, restores, and improves basic physical and mental abilities. It is therefore a form of opportunity: it is an external condition that can influence favorably what an individual attains in life. Consequently, the ideal of equality of opportunity provides a reason for promoting equality in health care, just as it does for providing equality in education.

Finally, lifting the financial burden of health care from individuals allows them to preserve the rewards

that effort and personal productivity have won them, instead of leaving these rewards to the mercy of illness and injury, which are so often a matter of chance. Health disasters can reduce to penury persons who have been hard-working and productive all their lives. This makes a mockery of reward for production and for effort.

The considerations just outlined—(1) providing a decent minimum, (2) establishing equality of opportunity, and (3) protecting rewards earned through effort and production from the ravages of chance misfortunes—can be grouped under the label of fairness. (1) and (2) have probably underlain what our society has done for some of the poor through Medicaid and for all of the elderly through Medicare. But (3) seems to argue for taking health care out of the private reward system altogether. Since chance plays such an important role in illness and injury, does not fairness to individuals require making sure that their financial status is not substantially altered through the cost of health care? In other words, does not fairness require us to pool health care expenses via some form of national health insurance to relieve individuals of the financial burden of their illness?

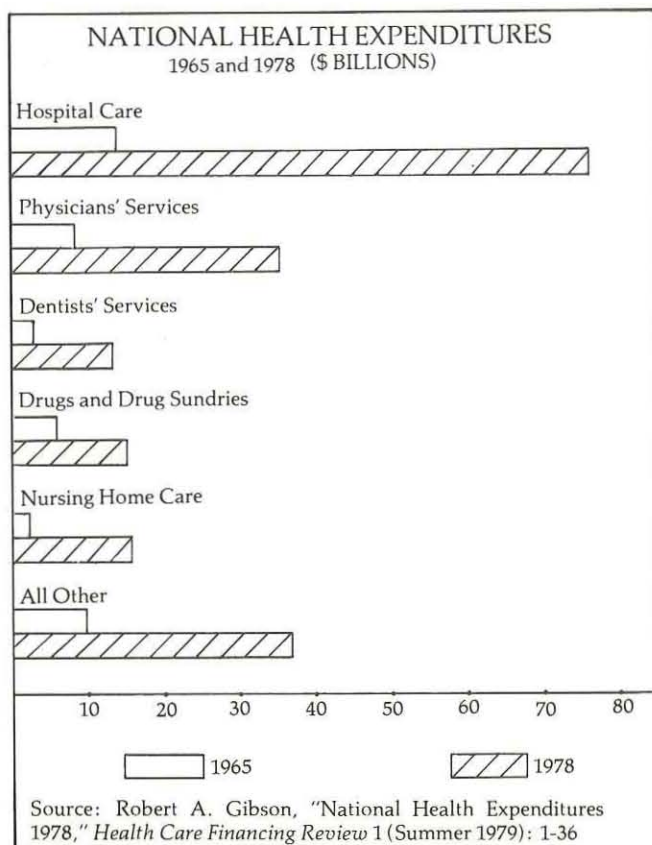
Enter Money

The headlong pursuit of fairness cannot, however, alone decide our national health care policy. What fairness seems to require is that every person be “adequately” insured against health expenses at all times. We fall short of that at present. Approximately 12 percent of Americans have no health insurance at all. As one would expect—since employers are the usual source of health insurance—many of the uninsured are unemployed. Those who are insured differ widely in the extent and depth of their coverage: working people with low incomes often have the worst coverage.

The simple remedy for this situation—seeing to it through government action that everyone is insured for a comprehensive list of services—will certainly drive up the nation’s health bill, perhaps in ways that are morally unjustifiable. To understand this, let us glance briefly at the steadily rising costs of our present health system and their explanation.

In the period between 1965 and 1978, whose beginning coincides with the establishment of Medicare and Medicaid, per capita spending on health care doubled in constant dollars. This steep rise can be explained in part by an aging and, consequently, increasingly infirm

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population and by the introduction of new costly medical treatments and technologies. But it can also be explained by the spread of health insurance. If we take into account both government programs—Medicare, Medicaid, the Veterans' Administration, etc.—and private health insurance, a massive change has occurred. In 1977, 94 percent of American families were covered by some form of health insurance, up from 63 percent in 1953.

Insurance increases the utilization of medical care, and no doubt much of the increase corresponds to indisputable medical needs that would otherwise be neglected. But not all services whose use is stimulated by insurance are indisputably needed. A great deal of medical care is discretionary. In the absence of insurance, both doctors and patients are influenced in their decisions about which services are necessary or desirable by the fact that the patient will have to pay. By contrast, insurance enables doctors and patients to make these decisions in a cost-free Nirvana. In the end, however, the world of everyday life intrudes: insurance premiums go up.

For that matter, insurance premiums do not accurately indicate to consumers what they are paying for health care. Insofar as premiums are paid by employers, the consumer experiences them, not as direct payments, but in the form of higher prices for other goods, since the employer passes on his costs. Employer-paid health insurance is tax-free for employees, moreover, and is not counted in the pay on which the employer's contribution to Social Security is based. These tax exemptions

are presumably made up by other taxes, but, again, consumers do not know what they are really paying for health care.

Under our present system, insurance companies have not effectively policed health care costs. Setting reimbursement standards that effectively monitor and restrain health costs is difficult and expensive for an insurance company. Much medical care is controversial: which is the best or appropriate treatment is often in doubt. Then, too, there is the question of what consumers want. What they have wanted in the United States is to pay little or nothing out of their own pocket for services (as opposed to paying for insurance), yet to have a free choice of doctors or hospitals. The result is insurance plans that pay any doctor's fee that is "usual, customary, and reasonable"; for the same reasons, the plans typically pay hospitals on the basis of the costs of the care they render or on the basis of their charges for that care. Insurance effectively eliminates price competition.

Our present insurance system, then, reduces competition and masks the costs of health care. Health services may conceivably cost most consumers more than they would be willing to pay if they had the money in their own pockets and were consciously choosing between health care and other goods. If this is the case, the system does not serve the best interests of most people—in other words, does not serve social utility. Yet the system still contains inequities. For example, it is estimated that only about a third of persons below the federal poverty line are covered by Medicaid.

The practical problem that confronts us, therefore, is to eliminate the residual unfairness of our health care system without causing too great a utility loss through rising prices. The importance of balancing these considerations is heightened by the expectation of further demographic aging of the population and new costly breakthroughs in medicine. Fairness itself can be imperiled if we do not heed the problem of costs: excessive federal spending on health care can channel funds away from other public needs, such as education, whose satisfaction, as much as health care, is a matter of fairness.

Perfect solutions to the conflict between fairness and cost control are hard to come by. In the economical state-run British system, controls on doctors and patients are more extensive than would be tolerated in the United States. Other Western European countries, such as France and Germany, basically provide insurance for fee-for-service medicine and have cost problems comparable to our own. In the United States, attempts to control costs through regulation have had little impact, and regulations that do succeed in controlling costs are themselves problematic. For is it really a good idea to restrict the services that patients can receive from doctors? Might this not frustrate important patient preferences? Might it not impede medical progress?

What we need is a system that has the flexibility of the private market in responding to consumer needs and

preferences, that stimulates cost-consciousness as the market does, yet guarantees an acceptable level of care for everyone in a way that the market cannot in a society characterized by large differences in income and wealth. How can this be achieved?

Solution Proposed

One promising solution is a system providing universal health insurance through vouchers for the poor and "refundable tax credits" for the non-poor, combined with measures to stimulate private competition among health insurance plans. Such a proposal has been offered by Alain Enthoven.

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Under the voucher portion of the system, the government pays for the cost of a private insurance policy selected by the poor person, covering certain stipulated essentials of health care (inpatient and outpatient hospital services, emergency health services, catastrophic insurance, and so on). To preserve work incentives, the voucher would vary with income, gradually declining as income rises. Medicare would continue, as a bow to political realities, and those currently covered would be able to retain their fee-for-service insurance. But Medicare insurees would also be allowed to receive average annual Medicare payments in a lump sum to be applied to the purchase of a private insurance policy. This will provide insurees with incentives to seek comprehensive care from prepaid group practices, which in general have proven more economical than the dominant fee-for-service medical sector. Enthoven expects that eventually it will be possible to abolish the fee-for-service element of Medicare and to give all entrants into the Medicare system a lump sum with which to buy the insurance of their choice.

Under the "refundable tax credit" portion of the system, a flat sum is deducted from the taxpayer's tax liability. It is "refundable" in this sense: if your tax liability is lower than the amount of the tax credit, the government will pay you the difference. The tax credit is a claim you have on the government if you buy health insurance (or if an employer buys it for you), and the claim can be settled by a refund. The tax credit would cover 60 percent of the cost of a minimum health insurance policy. Employees would be permitted to negotiate with their employers for part or the whole cost of such a policy, or of a more extensive policy. If the policy is

paid for by the employer, employees would receive their tax credit from the government in the form of cash.

Employer contributions under the Enthoven plan would differ in two important ways from present contributions. First, the employee has an incentive to choose a less expensive policy, since the amount of the employer contribution will be the same, whatever policy is chosen. Today the employer often pays the whole premium for any policy the employer chooses. Second, the employer contribution will no longer be tax-free, as it is now; it will count as taxable income for the employee. Once employer payments for health insurance become taxable employee income, the true cost of health insurance will become more apparent to the employee—who may therefore urge his or her union to negotiate for less health insurance and more wages.

The plan, then, allows for a variety of insurance policies suited to different tastes and permitting different forms of medical practice. Since the system is structured to provide incentives for choosing less expensive programs, the most economical insurance packages will be favored. Enthoven anticipates that the motor of the system will be the prepaid group practice. In such practices, groups of doctors work together at the same location to provide whatever health care is needed by persons voluntarily enrolled with the group. Since the same organization provides both the insurance and all insured services, costs are kept down. But the fee-for-service sector will make a competitive response, looking for new ways of lowering the costs of fee-for-service medicine.

It remains possible that American unions and employers would still prefer to establish comprehensive coverage of the highest-priced fee-for-service health care, even if such a proposal became law. In that case, we would know that Americans like the kind of health care they have when its costs are no longer hidden. It would be worthwhile to find that out. But in fact it is likely that the American health system would respond to the new structure of incentives.

This proposal, then, has the following strengths. It provides everyone with a modicum of health care. Thus it recognizes that some health needs are objective and vital and that health care is an important component in equality of opportunity. It also recognizes that much illness and injury is simply bad luck, which should not be allowed to burden the individual financially like an item of voluntary consumption. On the other hand, it permits some differences in personal investment in health insurance, thus acknowledging that much health care ministers to less urgent needs, perhaps even to tastes rather than to needs; further, that the efficacy of many health services is disputable. It promises to contain costs by restructuring the system of incentives to encourage consumers to economize in purchasing health care. Finally, it works by incentives, not by regulations; thus it can be resisted by the American people if their concrete preferences and values run counter to it.

Altogether, not a bad idea.