US Healthcare: Could A Free Market System Work?

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For the last few months, Republicans have had trouble coming up with a replacement plan for US healthcare.

The main problem with the Republicans' proposal is that it only partially repeals Obamacare. Another is that US healthcare has seen rising costs since the late 60s, meaning that reform has to go past merely repealing Obamacare.

Obamacare is a symptom of the US healthcare system, namely the fact that insurance companies are an integral part of it. Obama, rightly, felt the need to address the insurance market, and though this was an admirable approach, it may not have been the correct one.

An Overview of US Healthcare

To understand the Republicans' predicament, an overview of the American healthcare system is essential.

In 1958, insurance companies were relatively minor in the US healthcare industry. Only 35% of personal health expenditures came from insurance companies (third parties) and the other 65% came directly from the family's pocket. However, today, only 9% of personal health expenditure comes from the pocket, and an increasing amount either comes from the government or insurance companies.

As a result, third parties dominate the health industry, rather than buyers (patients) and sellers (doctors). Given the rise of insurance-based healthcare, health management organisations (HMOs) that require employer contributions, the IRS thus gives tax breaks employer-provided health insurance.

As a result, employers have an incentive to provide extensive health insurance, which covers a wide range of services as opposed to just the most serious eventualities.

Obamacare and the HMO Act 1973

Obamacare's key provisions include the individual mandate, which forces insurance companies to charge pre-existing conditions the same sum as healthy patients and also sets up health insurance marketplaces in individual states.

An HMO is an insurance group that provides healthcare at a fixed annual fee. HMO covers care given by those doctors and other professionals who have agreed by contract to treat patients in accordance with the HMO's guidelines and restrictions in exchange for a steady stream of customers. Pursuant to the HMO Act 1973, employers who have more than 25 employees must offer federally certified HMO plans.

Medicare and Medicaid

Medicare was created in 1965 with the purpose of providing care for senior citizens.

Medicare Part A covers a wide range of services for senior citizens. Whatever services a patient requires, the doctor or nurse can give the medical bill to the taxpayer who will cover it. The taxpayer covers hospital care, hospices and nursing care.

Medicare Part B covers two services: the necessary services that are needed to treat a medical condition as well as preventative care. George W. Bush signed Medicare Part D into law in 2005, which expanded the program by covering prescription drugs.

Medicaid's main purpose is to make sure that the poor have access to healthcare. Medicaid aims to co-pay the patient's health insurance coverage provided their income falls under a certain income threshold. It also covers medical services for impoverished children such as dental care.

The Fundamental Flaws

As many know, the US spends 18% of its national income on healthcare whilst also having fairly appalling outcomes. However, this was not always the case; in 1958, Americans spent just 3% of income on healthcare.

In theory, the US should be able to replicate the healthcare system of the 50s and structure expenditure around it. To do this, out of pocket payments must become the major component of healthcare spending. in 2012, as much as one-fifth of doctors' time and money was spent dealing with paperwork, rather than treating payments. The paperwork has, of course, arisen out of partnerships with third parties.

According to a Cato Institute study, if 100% of a patient's spending came from their pocket, rather than insurance companies or Medicare/Medicaid, healthcare spending in the US would be below 10%.

Role of Third Parties

The main problem is that doctors and drug companies don't compete because much of health expenditure in the US is either directed by Medicare, Medicaid, HMO Act 1973, Obamacare and insurance companies.

In other words, third parties dominate healthcare rather than patients and doctors. The problem with these third parties covering healthcare is that consumers and doctors do not care about prices or keeping costs down because someone else is always paying for healthcare.

As a result, patients do not use their resources effectively because the link between a consumer's wallet and the doctor has broken down. The HMO Act 1973 increased the importance of insurance plans in determining access to healthcare.

For example, one does not buy home insurance for something as simple as electrical faults. However, this does is not the case for health insurance. Increasingly, Americans are buying health insurance for a wide range of services, including basic services such as GP checkups rather than solely life-threatening illnesses.

Consequently, insurance now accounts for 90% of personal expenses on healthcare. What is worse is that employees and employers get tax benefits for healthcare, leading to the purchase of unnecessary health plans.

Medicare covers a wide range of doctors' services. As a result, given that doctors can simply ask the taxpayer to shoulder the medical bills, doctors have no incentive to cut costs. In addition, producers of medical technology can sell equipment that barely improves medical services without reprisal. Even if they sell expensive medical equipment to doctors, doctors can pass on the prices to consumers.

However, given that insurance companies and the government are now the dominant spenders, the consumer is not concerned. As a result, a Heart Valve Replacement surgery costs $170,000 in the USA but just $17,000 in Singapore, precisely because Singaporeans rely more on health savings accounts (HSAs) and make direct out of pocket healthcare payments.

Lack of Competition in the Drug Industry:

Drugs in the US seems to be a topic that angers many people and rightly so. For example, since 2007, the price of an EpiPen has risen 600%. The first reason is that Medicare is biggest buyer of drugs. Medicare Part D states that the government cannot negotiate drug prices.

Another problem is that the US does not allow imports of drugs. Tearing down protectionist barriers for drugs would mean that, overnight, American drug companies would have to compete with Canadian, Singaporean and European drug manufacturers produce medicines at more reasonable prices.

Repealing Major Healthcare Legislation Since 1965

One place to start is to repeal all of the aforementioned government programs implemented since 1965. This entails phasing out Medicare, Medicaid, Obamacare and the HMO Act 1973.

Repealing these major government programs would lead to a sudden loss in third party payment from the government for healthcare. Medicare and Medicaid should be replaced with a voucher-based safety net. Currently, the problem with Medicare and Medicaid (and the extensions) and the HMO act all set prices of healthcare and drugs.

The government should not be setting prices. When governments introduce price controls, they reduce the incentive for doctors to enter the market and leaves more people, usually the poor, without healthcare.

Outlawing Medical Insurance Companies

Medical insurance has proven to be problematic for the US healthcare system. While the government could simply pass legislation to restrict health insurance to only catastrophic coverage (e.g. heart transplant), insurance companies would still not cover people with heart conditions even if the risk of needing a heart transplant is low.

Secondly, retaining catastrophic insurance still does not address the high administrative costs for doctors and the headaches that ensue. Therefore, the solution is to outlaw medical insurance and ban insurance in the medical industry under all circumstances.

Thus, the intermediaries are out of the healthcare system and 100% of expenditure is directly from the patient's pocket. Also, doctors usually treat whoever walks through the door, regardless of their condition. In fact, doctors can save money and time on paperwork, which leaves them with more time to treat patients.

Under such a system, doctors would only accept patients' money, for which they have to compete. In Singapore, the majority of health expenses directly from people's pockets. Furthermore, in the US, Lasik surgery costs less and less each year because neither insurance companies nor the government covers it, and thus doctors have to compete for consumers.

The only role of government in this new system would be to give money to the poor and elderly, who in turn spend that money in the marketplace as opposed to covering doctors' fees. The prices of many major surgeries and procedures in Singapore are considerably less than the US. Therefore, the numbers speak for themselves; direct spending means lower prices.

Removing Barriers to Entry

By repealing Medicare Part D and eliminating import tariffs for clinically-proven drugs would give patients access to cheaper drugs. The competition will lower prices. Additionally, the government should double its R&D budget for drug research.

In order to increase the number of doctors in society, medical school and university needs to be cheaper. This would mean abolishing the Department of Education, which is largely responsible for very high tuition fees at both the undergraduate and postgraduate level. Furthermore, the government could require medical schools across the country to increase medical school places by 25%. The UK has done this for next year's A-level students.

However, the 1986 law that forbids doctors from turning people away who are poor and are in need of emergency care must stay in place. Hospitals have to treat anyone who comes through the door and are in need of emergency care. Hospitals could also accept and campaign for charitable donations to help improve their services.

Health Savings Accounts and Empowering the Consumer

As in Singapore, the government should withhold 7% of one's pay cheque and deposit it into a health savings account (HSA). This requires each household to open up a regular bank account, which will act as its HSA.

The HSAs also have one major advantage. It allows people of the same age group, medical condition, occupation or even family members and friendship circles to purchase healthcare together as a single entity, and all share the same plan.

For example, an 85-year-old grandmother may be at risk of a heart attack. This makes her a high-risk patient. Hence, she can pool her resources with her children and grandchildren and as a family; they can all share the same health savings accounts and use that HSA to shop around for the best doctor and cheapest prices.

As a further example, a town of, for instance, 1000 coal miners may all be at risk of respiratory problems. If each of these men have pooled into a shared HSA, they would all be able to share the burden of paying for healthcare if one should actually fall ill, knowing full well that the same would be done for them.

Medical Tourism

Given that consumers are free to choose to spend their HSAs without pressure from third parties, it gives them much more freedom.

As a result, people can take their medical money to purchase healthcare abroad. As a result, American doctors would not just be in competition with each other; they would be in competition with the world.

Therefore, American doctors will have to provide better quality services and producers of medical equipment would need to produce better equipment to be internationally competitive. The absence of third parties from healthcare would lead to a 'globalisation of medicine.

Designing the Social Safety Net

A feasible solution to the US healthcare crisis is henceforth set out.

Instead of Medicare, each senior citizen could simply get $7,000 per annum to purchase the healthcare. A married senior couple would get $14,000. Another advantage of the HSAs are elderly couples can merge their $14,000 with their grandchildren and extended family, to purchase healthcare in case $14,000 does not go far enough.

As mentioned earlier a Heart Valve Surgery is $17,000 in Singapore. If third parties are removed from the US healthcare system, then since GDP per capita in the US is the same as Singapore, the price of heart valve surgery could fall to $17,000.

Given that a married couple has $14,000 for the year from the government (let alone their own savings), they have several options. They could firstly travel to India and get the surgery for less than $7,000. Or they could pay $14,000 to the doctor, leaving a $3,000 deficit. They could bridge that gap either through use of private charity, the doctor could forgive $3000, or they could pool their HSAs with their kids' and grandkids' who are healthier and do not need as much money.

As a result, the elderly couple's descendants may contribute the $3,000 and hence a major surgery is now accessible to all seniors, thereby reducing inequality in healthcare.

As for reforming Medicaid, which is designed to help the poor and middle classes, these aims could continue, albeit differently.

Households earning between 0% and 200% of the poverty line can get a $2,000 per person cheque deposited in their HSAs. A poor family of four will, therefore, get $8,000 per year in healthcare vouchers. $8000 might well be too much, so the family will have cash that they could save or invest.

For households earning between 200-300% of the poverty line, the pay-cheques could reduce by $20 for every 1 percentage point above the 200% threshold. In short, if someone earns more than 300% of the poverty line, they would get no government assistance.

Crunching the Numbers

Approximately 32.5% of the population earn between 0-200% of the poverty line. This equates to 103m people falling in this category. Therefore, $2000 per person means that this group will cost approximately $206bn each year. A further 70 million people live between 200 and 300% of the poverty line. One can assume an additional cost of $100bn for this group.

Therefore, the total cost of a replacement for Medicaid would be around $306bn per year, and since there are 50m senior citizens in the US, Medicare will cost approximately $350bn per year

to replace. A further $30bn should be committed to R&D subsidies. Consequently, the federal government would spend $636bn on healthcare each year.

Since the federal government currently spends $1.1trn per year on healthcare, the US could arguably save well over $400bn if it pursued free market healthcare reforms.