THE RIGHT PRESCRIPTION

The Real Health Care Debate: Who Decides?

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The debate over health care is rushing to a climax. Hundreds of thousands if not millions of words have been spilled over the details of competing plans to federalize American health care. But the basic issue is simple: Who decides?

The issue is not one of public versus private. The U.S. system is an inefficient hybrid, with government paying nearly half of the bills and shaping private spending through the tax preference for employer-provided insurance. The result is a third party payment system in which nearly nine of ten medical dollars is paid in the first instance by someone else.

No surprise, national outlays are high and rising. Too many people -- whatever the exact number -- lack adequate coverage for health care crises.

"Reform" is a question of direction. Expand government, and especially federal, control. Or increase patient choice and private options.

The former is the favorite in Washington. And it means more fully turning control of health care over to politicians, bureaucrats, and assorted "experts." Indeed, that's the very purpose of Democratic "reform."

During the Clinton health care debate, Wall Street analyst Kenneth Abramowitz advanced the cause of managed care: "Right now, health care is purchased by 250 million morons called U.S. citizens," he said. It was necessary to "move them out, reduce their influence, and let smart professionals buy it on our behalf."

Do we believe that "smart professionals," whoever they may be, can best decide how much health care we receive from whom for what conditions? Should "smart professionals" decide how we are treated? Giving the federal government the power to make these decisions is what Obamaesque "reform" is all about.

It is a frightening possibility.

"Reformers" start with the assumption that "we" spend too much on health care. Nowhere else in the economy do we act as if there is a proper proportion of the economy that should be expended on an activity. Do we spend "too much" on automobiles? What is the "right"

percentage of GDP to devote to beer? Should society reduce or increase outlays on art?

These are stupid questions. Bad incentives as a result of third party payment mean we buy medical care inefficiently, we spend more than we should for what we receive in return. But it makes no sense to total up expenditures on health care and let the government decide whether they are appropriate.

After all, we don't complain about national spending on cars, beer, art, or anything else. Spending on these are properly personal decisions by people using their own resources. If someone wants to devote more money to paintings and less to housing, that's what liberty is all about.

So it should be for health care.

The U.S. is a wealthy society with an aging population. New technologies, drugs, and devices can greatly enhance the length and quality of Americans' lives. But every decision involves a trade-off, since demands are infinite and resources are finite. Despite what the president and congressional Democrats would have us believe, it is impossible to simultaneously enhance choice, improve quality, increase access, and cut costs. There ain't no such thing as a free lunch, no matter how much politicians might claim otherwise.

Given the importance of medical care -- most people are more concerned about the condition of their heart than their car -- it is particularly important for individuals to make the inevitable and difficult trade-offs. Obviously, choosing health care is more difficult than buying an auto; people usually need advice from "smart professionals." But no matter how well-intentioned and knowledgeable, "smart professionals" are not equipped to decide how much we pay for what coverage for what services provided by which professionals.

Yet that's what government health care programs do in the U.S. If public money is being spent, whether by a state or the federal government, then government has to make decisions about how much will be spent for what purpose. It is inevitable, but not the sort of decision government should make for everyone else.

For example, the Centers for Medicare and Medicaid Services warns that passage of the Democratic "reform" proposal would require Medicaid rationing: "It is reasonable to expect that a significant portion of the increased demand for Medicaid would not be realized."

And deciding on government coverage is inherently political. The authors of a study of Oregon's experience in attempting to objectively rank order procedures that it covered under Medicaid found that the system "has not operated as the scientific result of rationing that it was advertised to be." Instead, "controversies around the list forced administrators to make political concessions and move medical services 'by hand' to satisfy constituency pressures and the federal government."

Imagine government making health care decisions for all Americans in the same way.

That is what foreign nationalized systems do. For instance, in December 1993, as Congress was debating the Clinton health care proposal, the Canadian province of Ontario busted its "global budget," which forced it to end all but emergency medical care. You could buy an automobile or beer or painting, but not get elective medical treatment.

Last month, in the midst of the debate over the Obama health care proposal, Newfoundland premier Danny Williams flew to Miami for a heart operation. Canada's system offered only limited treatment options. Williams rebutted criticism of his decision: "This was my heart, my choice and my health."

Waiting lists in Britain and Canada run in the hundreds of thousands and wait times for treatment run in the months. In many cases care delayed is effectively care denied. In a case challenging the prohibition on private insurance, the supreme court of Quebec observed the obvious: "Access to a waiting list is not access to health care."

In many cases the rationing is explicit. For instance, Britain's National Institute of Health and Clinical Effectiveness (NICE) makes blunt, brutal judgments about cost and efficacy, denominated in terms of Quality Adjusted Life Years. The British government decides that some people's lives simply aren't worth saving given the required expense. Every British citizen is stuck with the result.

NICE has barred reimbursement for the drug Revlimid to treat myeloma, turned down use of Alzheimer's pharmaceuticals which cost just a few dollars a day to use, blocked coverage of Abatacept for rheumatoid arthritis, refused to authorize medicines to treat macular degeneration -- unless patients have already lost sight in one eye -- and even limited use of cortisone for back pain. Reported the *Daily Telegraph*: "Specialists said when they did alert terminally-ill patients to the existence of drugs which could extend their lives by months and in some cases years, the patients were often angry to learn that the NHS was unlikely to fund their treatment." So British doctors often don't tell patients about available treatments.

Two years ago NICE attempted to enforce its denial of Avastin to breast cancer patient Debbie Hirst by threatening to withdraw all medical coverage through the National Health System if she bought the medicine herself. NICE explained that "topping off," as it was called, violated the national commitment to equality. NICE reversed course only because of the ensuing political firestorm.

President Barack Obama and similar "reformers" have proposed all sorts of procedures, panels, and requirements to ensure that only "cost-effective" care is delivered. But just as there is no federal budget line for "waste, fraud, and abuse," there often is no simple, single correct treatment for all diseases.

Proponents of government control dismiss such concerns. After all, they contend, "rationing" is inevitable. Either the government will do it. Or someone else, particularly insurance companies, will do it.

But government rationing is not the same as individuals exercising free choice in a market. There is a dramatic difference between deciding how to distribute limited goods and services for others and deciding how to balance competing goods and services for oneself. Today employers have too much control over individual insurance plans; the answer is not to transfer that control to politicians, but to return it to patients.

Consider the recommendation last fall by the U.S. Preventive Services Task Force to drop routine mammograms for younger women. Patients, doctors, and analysts all can disagree about the value of doing the test annually. There's no reason there should be only one national

standard, set by the government.

Yet proposals for federally enforced "comparative effectiveness research" risk creating just such a system. CER could be a useful guide for treatment, but more likely would turn into a limit on treatment. After all, NICE began, according to the *Guardian*, as an agency "designed to ensure that every treatment, operation, or medicine used is the proven best. It will root out under-performing doctors and useless treatments, spreading best practices everywhere."

Admittedly, today's system only intermittently protects individual choice. The third party payment process has increased efforts by public and private payers alike to restrict coverage and treatment of patients. With only six percent of insurance policies purchased in the individual marketplace, few Americans actually choose their own policies; most employers, no less than Medicare and Medicaid, decide on people's coverage. Nevertheless, the availability of the (imperfect) individual market, competitive pressure on employers, and opportunity to change jobs leaves many people with some options. Government control ultimately means no exit for anyone -- except the wealthy, who can opt out of the system entirely.

The lack of adequate choice today indicates the proper objective of real reform: increased patient power. People need a medical system that allows them to make basic health care decisions, especially what kind of insurance to buy and what kind of coverage to choose.

Such decisions are complex and people with little means will need assistance. But the appropriate trade-offs vary dramatically based on individual and family preference and circumstance. Patients, not government, should make these decisions. Two of the most obvious steps to encourage consumer-directed care are ending the tax preference for employer-provided policies and eliminating state-mandated benefits. Public spending should be concentrated on the areas of greatest need: providing for the poor and uninsurable.

The American health care system is inefficient and costly. Too many people don't get consistent and quality care. "Reform" is necessary.

But only the right type of reform. The answer is not increased political control, but increased patient control. The length and quality of our lives are too important to turn health care decisions over to politicians, bureaucrats, "smart professionals," or anyone else.

Doug Bandow *is a senior fellow at the Cato Institute. A former Special Assistant to President Ronald Reagan, he is the author of* Beyond Good Intentions: A Biblical View of Politics *(Crossway).*