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Re-Reforming Health Care

By Doug Bandow

The basic issue of health care reform was simple: Who decides? The Democrats' answer: The government.

But the battle is not over. The fight continues.

The U.S. medical 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 10 medical dollars are paid in the first instance by someone else.

No surprise, national outlays are high and rising.

"Reform" was necessary, but in what direction? Expand government control? Or increase patient choice?

The former was the favorite in Washington. During the Clinton health care debate, Wall Street analyst Kenneth Abramowitz opined: "Right now, health care is purchased by 250 million morons called U.S. citizens." It was necessary to "move them out, reduce their influence, and let smart professionals buy it on our behalf."

"Reformers" started with the assumption that "we" spend too much on health care. In fact, bad incentives as a result of third-party payment meant we buy medical care inefficiently.

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.

New technologies, drugs and devices greatly enhance the length and quality of Americans' lives. Given the importance of medical care, individuals should make the inevitable and difficult trade-offs.

Obviously, choosing health care is more difficult than buying an auto. But no matter how well-intentioned and knowledgeable, "smart professionals" are not equipped to decide how much we

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pay for what.

If public money is being spent, government has to make decisions about how much will be spent for what purpose. But that is not the sort of decision government should make for the rest of us. With Obamacare, this sort of government control is inevitable.

Deciding government coverage is inherently political. An academic review warned that Oregon's Medicaid 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."

This is what foreign nationalized systems do also. In February, in the midst of the debate over the Obama health care proposal, Newfoundland Premier Danny Williams flew to Miami for a heart operation. Mr. Williams explained: "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. The Supreme Court of Canada observed in a challenge to the Canadian system: "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) judges cost and efficacy in terms of "quality-adjusted life years." The British government decides that some people's lives simply aren't worth saving.

NICE has barred reimbursement for the drug Revlimid to treat myeloma, blocked coverage of Abatacept for rheumatoid arthritis and refused to authorize medicines to treat macular degeneration - unless patients already have lost sight in one eye.

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 [National Health Service] was unlikely to fund their treatment." So British doctors often don't tell patients about available treatments.

Proponents of government control attempt to reassure us by saying that "rationing" is inevitable. Either the government will do it or someone else, particularly insurance companies, will do it.

But there is a dramatic difference between government deciding how to distribute limited resources for others and individuals deciding how to balance competing desires for themselves.

Today, employers have too much control over individual insurance plans. The answer is to return control to patients.

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. Obamacare won't do that.

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.

An election is coming in November, and many of the new bill's provisions won't take effect for years. The battle cry now must be repeal and real reform.

Real reform means increased patient, not government, control. Our lives are too important to turn health care decisions over to politicians, bureaucrats, "smart professionals" or anyone else.

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