# Larry N. Smith and Stephen T. Parente: Tax system can foster rational health care reform

*Published: Thursday, April 22, 2010 at 9:55 a.m.*

As the health care reform debate heats up, the true costs and the complexity of the issue are finally coming to the surface. Sticker shock has moderated many proponents of reform, but for many the attitude nevertheless seems to be "damn the tax increases, full speed ahead into some reform." It is important to keep in mind, though, that the costs of reform will come in more than money.

In the push to nationalize health care, it will be liberty that is truly the sacrificial lamb, as pointed out at the June 17, 2009 CATO Institute Healthcare Reform Symposia. The reality is that the current health care system can expand coverage, lower costs and allow for the patient and the doctor to maintain the constitutional freedoms that we all enjoy, without changing the coverage of the 85 percent of Americans who now have health care access.

Expanding coverage to the 47 million uninsured Americans can be accomplished through simple accounting and tax code changes. These changes would allow doctors to deduct the uncompensated health care they provide from their year-end taxable earnings. Physicians are already providing uncompensated coverage all across America, and in Florida, doctors and hospitals provide free care through the We Care Program, specifically for the uninsured.

The doctor would deduct the dollar amount of care that is representative for that level and quantity of service, based on the dominant regional payer's reimbursement for such care. In effect, this change elevates the uninsured patient to a fully insured status, and costs the IRS a small incremental decrease in tax revenue. Plus, the physician and hospitals are rewarded for providing a valuable aggregate social service and these 47 million get comprehensive care.

Of course, physicians are mandated by law to provide care through the hospital emergency room already, but generally they do not collect for these services, although they're still a target of litigation for such services.

This simple change in code would mitigate these issues, and it would also help patients who, because of illness, lose their jobs and are in fear of bankruptcy. By allowing the health care provider to deduct the ongoing uncompensated costs, the patient's care is not interrupted and physicians can continue to meet their moral obligations, which the vast majority already do without compensation.

While the fundamental health care model is workable, that does not mean that it does not have room to improve, especially on the cost side of the equation. One issue is the geographic difference in costs for the same risk-adjusted medical condition without better outcomes, as noted in a Dartmouth study. This problem must be addressed and mitigated.

With the tax changes noted above, costs can be mitigated since disproportionate share payments to hospitals could be decreased, because the hospitals would receive tax benefits for providing uncompensated care. This change would save the states tax revenue, which can be used elsewhere. Moreover, the hidden cost of the uninsured is eliminated, as there is no need to pass on these costs in the form of higher fees for

everyone else.

Costs can also be controlled by the government supporting, but not designing, local, regional and national practice guidelines. Once adopted by specialty societies and followed by physicians, these guidelines would insulate the physician from frivolous litigation but also control for regional cost differences.

As these care-standards come online, cost comparisons can be undertaken to determine the true balance between quality and cost effectiveness, with the understanding that the cheapest treatment may not always be the best.

Third, local health care systems need to be allowed to coordinate care into integrated systems free of federal anti-trust laws, which currently prevent the open exchange of charges and practice data. The patient is the ultimate beneficiary of such changes, since transparency for costs and outcomes can be made available through integrated community networks.

Some doctors may stay in private practice, while others may choose to merge into single or multi-specialist groups, but the goal would be for them to be linked electronically with systems designed and integrated by health care providers.

With these changes, Regina Herzlinger's and Alain Enthoven's visions of patient-directed health care within a system that is integrated, transparent and conscious of the quality-to-cost balance would be achieved. There may be from one to twenty such competing systems within a community, but quality and price competition will drive the market. Rural physicians and hospitals may receive incentives to participate in several networks, depending upon their areas of proven excellence. In the end, the patient benefits.

This is not to say that government assistance would not be needed, but it should be temporary, focused and supportive.

Much is made of the cost of American health care, which represents 17 percent of the GDP. However, no one discusses the fact that medicine only produces healthy workers who are returned to the workforce; a valuable service to the economy but difficult to assign an economic value to. A healthy worker who contributes to the GDP has an innate economic value.

Similarly, the economic value that medicine contributes to the GDP by supporting General Electric, Johnson and Johnson, Eli Lilly and those in other health care-related industries is not calculated. These two values should be subtracted from this 17 percent of GDP to account for the positive impact that medicine has.

As an end-stage consumer and provider of health care, medicine's contribution to the economy is often overlooked since it produces nothing to sell.

Within these changes, health care could be maintained within a market based system among patients, doctors, hospitals and private insurers. If the government is allowed to provide a public health care option, then the option will become the dominant single-payer insurance product, as so clearly outlined by David Hyman. Such a move could denigrate the personal choices Americans currently have, while running all other insurance companies out of business. Costs would be controlled by lowering reimbursements to providers by using the Medicare fee schedule - plus 5 percent to 10 percent, as an index for payment.

One need only study the national healthcare systems around the world to know that a public option could mean long lines, limited access to technology and lower-quality care. Between 1946 and 1952 doctors working with the AMA, American College of Surgeons, and Blue Cross and Blue Shield increased the number of insured from 22 percent to 55 percent. The free market can do it better and should.

As noted by our Founding Father Benjamin Franklin, "Those willing to sacrifice liberties for security deserve neither." Similarly, anyone willing to sacrifice liberties for health care will have neither.

Dr. Larry N. Smith is a fellow of the American College of Surgeons and an adjunct professor at Santa Fe College, in Gainesville. Stephen T. Parente is an associate finance professor at the University of Minnesota, Minneapolis, and director of the university's Medical Industry Leadership Institute. This opinion piece was originally published in the Washington Times.