ROLL CALL

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Tanner: Reform Must Empower the Consumers

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As Congress moves forward with proposals for reforming the U.S. health care system, it is possible to draw some important lessons from the experience of other countries.

First, universal health insurance does not mean universal access to health care. In practice, many countries promise universal coverage but ration care or have extremely long waiting lists for treatment.

For example, at any given time, 750,000 Britons are waiting for admission to National Health Service hospitals, and shortages force the NHS to cancel as many as 50,000 operations each year. In Canada, more than 800,000 patients are on waiting lists for medical procedures. The Canadian Supreme Court has found that many of these individuals suffer chronic pain and that some die awaiting treatment.

Those countries that have single-payer systems or systems heavily weighted toward government control are the most likely to face waiting lists, rationing, restrictions on the choice of physician and other barriers to care. Those countries with national health care systems that work better, such as France, the Netherlands and Switzerland, eschew centralized government control and incorporate market mechanisms such as competition, cost-consciousness, market prices and consumer choice.

Second, rising health care spending is not an uniquely American phenomenon. While other countries spend considerably less than the U.S. on health care both as a percentage of the gross domestic product and per capita, it is often because they begin with a lower base of expenditures. But their costs are still rising, leading to budget deficits, tax increases and/or benefit cuts. As the Wall Street Journal notes, “Europeans ... face steeper medical bills in the future in their cash-strapped governments.” In short, there is no free lunch.

Yet many in Congress naively think that if we simply expand coverage, cost control will take care of itself. If, as expected, health care reform costs $1 trillion to $1.5 trillion over the next 10 years, Americans should brace for massive tax increases — and not just for the wealthy. In fact, many of the tax increases being considered to pay for health reform — taxing employer-provided health benefits; soda and beer taxes; restricting or eliminating flexible spending accounts and health savings accounts; eliminating the deductibility of health expenses above 7.5 percent of adjusted gross income, etc. — fall heavily on the middle class.

Moreover, current estimates probably understate the actual cost of health reform. The Urban Institute, for example, suggests the actual cost will be closer to $2 trillion, noting: “If all uninsured people were fully covered [in 2008], their medical spending would increase by $122.6 billion.” If we assume that the cost of covering the uninsured will grow at the same rate the federal government assumes for all health spending growth (6.2 percent), then from 2010 through 2019 the cost of covering the uninsured would be $1.8 trillion.

Furthermore, cost estimates for government programs have been wildly optimistic over the years, especially for health care. For example, when Medicare was instituted in 1965, it was estimated that the cost of Medicare Part A would be $9 billion by 1990. In actuality, it was $67 billion. Similarly, in 1987, Medicaid’s special hospitals subsidy was projected to cost $100 million annually just five years later; it actually cost $11 billion, more than 100 times as much. And in 1988, when Medicare’s home care benefit was established, the projected cost for 1993 was $4 billion, but the actual cost was $10 billion. If the current estimates are off by similar orders of magnitude, we would be enacting a new entitlement that could bury future generations under mountains of debt and taxes.

Finally, the broad and growing trend in countries with national health care systems is to move away from centralized

government control and to introduce more market-oriented features. As Richard Saltman and Josep Figueras of the World Health Organization explain, “The presumption of public primacy is being reassessed.” The growth of the government share of health care spending in European countries, which had increased steadily from the end of World War II until the mid-1980s, has stopped, and in many countries, the private share has begun to increase, in some cases substantially.

Other countries are loosening government controls and injecting market mechanisms, particularly cost-sharing by patients, market pricing of goods and services, and increased competition among insurers and providers. Pat Cox, former president of the European Parliament, said in a report to the European Commission, “[W]e should start to explore the power of the market as a way of achieving much better value for money.”

There is even evidence of a growing shift from public to private provision of health care. If many of the proposals in Congress would push us toward more of a European-style system, the trend in Europe is toward a system that looks more like the U.S.

If there is a lesson that U.S. policymakers can take from national health care systems around the world, it is not to follow the road to government-run national health care, but to increase consumer incentives and control. The U.S. can increase coverage and access to care, improve quality and control costs without importing the problems of national health care.

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