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Private alternatives

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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 still 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, liberty will be truly the sacrificial lamb, as noted at the June 17 Cato Institute Conference on Health Care Reform.

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.

Coverage can be expanded to the 47 million uninsured Americans 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 would elevate the uninsured patient to a fully insured status, and costs the Internal Revenue Service 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.

Though the fundamental health care model is workable, that does not mean it does not have room to improve, especially on the cost side. 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 money that 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 and also control regional cost differences. As these care standards come online, costs can be compared 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 antitrust 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, the visions of Harvard Business School's Regina E. Herzlinger and Stanford University's Alain Enthoven 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 20 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 gross domestic product. However, no one discusses the fact that medicine only produces healthy workers who are returned to the work force -- 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 Co., 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, the option will become the dominant single-payer insurance product, as so clearly outlined by the Cato Institute's David Hyman. Such a move could denigrate the personal choices Americans 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 health care 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 American Medical Association, 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.

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