Thoughts on Health Care

Last Thursday morning, at the invitation of Ivan Ketterman (Outrigger’s Corporate Director, Taxation), I had the opportunity to address the Metropolitan Rotary Club in Honolulu on the debate now raging around the proposed health care bill that Congress is considering and President Obama is strongly advocating. I spoke about what is right and wrong with our current system of health care and health care insurance, the problems with the plan that the President and the Congressional leadership are pushing, and the healthier, more effective steps that I recommend as an alternative. Following is the text of the remarks I made:

Good morning and Aloha! I am honored to be with you today to discuss something that’s very much in the news – and that I feel very passionate about: Health Care and How to Pay for It.

I am in a great position to discuss this topic, since I have observed it through three different lenses:
• First as a physician.
• Also as a patient – I’m 75 years old, and I have Parkinson’s disease, so I have a little experience with the system.
• And finally, as a business owner responsible for providing health insurance to thousands of employees and their family members.

I’m a taxpayer too, so like all of you, I’ve also got some experience in sharing the cost of Medicare and Medicaid, which, combined, consume an entire third of our gargantuan federal budget.

Health care is a complex subject. I only have 25 minutes, so I’ll try to shed a little light on the basics and give you a few things to chew on that you might not be aware of if your main source of information is the media or messages put out by the White House and Congress.

I’ll begin by talking a bit about what’s right and wrong with our system now.

Then, I’ll discuss the problems with the proposed reforms the President and many in Congress are trying to rush through.

Finally, I’ll give you my prescription for a system that works better for everyone.

Before I go any further, I want to make clear that I’ll be focusing today on how we PAY for health care. Health care and health insurance are not the same thing.

Let’s start with a look at what’s right and wrong with our current system.

As David Gratzer, a physician who’s written an excellent book on the subject, says: “Everybody agrees that it is the best in the world, but nobody really likes it.”

Actually, most Americans are satisfied with the health care they get. According to a May 2009 survey, 62 percent of Americans—including those WITHOUT health insurance—rate their health care good or excellent. Other surveys put the proportion much higher.

I believe this has to do with the fact that our health care system, and the science and resources behind it, have kept us healthy enough to have raised the average American’s life expectancy more than one-third in the past six decades – from 57 to 78 years.

This prompts me to make a short detour for the sake of perspective. One health care myth is that its costs are soaring. That’s not entirely true. While we’re certainly paying more, we’re also getting much better care today than we did a few decades ago. That’s why life expectancy has risen so dramatically.

As an astute observer has pointed out, “You can’t get 2009 health care at 1950 prices. Today’s health care would have looked like science fiction just a few years ago.”

Science fiction turned real doesn’t come cheap. So we actually get great VALUE for our health care dollars.

Now back from the detour…
Of the things that are wrong with our current health care system, probably the most widely cited is that some 46 million residents of this country are said to lack health insurance. The President has claimed 47 million, and he is using this number as the main reason for the effort to legislate “universal coverage.”

So let’s examine the claim about those 46 or 47 million, actually 45.7 million, according to the Census Bureau.

Douglas Holtz-Eakin, the former Director of the Congressional Budget Office, calls this number “incomplete and potentially misleading.”

Nearly 10 million of them are not citizens – including many, estimated at over 7 million, who are here illegally.

This is not to say that anyone in need of medical care should be denied it, but it is at least debatable whether U.S. taxpayers should fund insurance for them.

These non-citizens bring the number of “uninsured Americans” down to 36 million.

Over 9 million more of the uninsured earn more than $75,000 a year. Most could presumably buy coverage.

As Dr. Gratzer puts it, “Many Americans are uninsured by choice.”

Finally, many of the uninsured already qualify for existing government health insurance programs but haven’t signed up. Estimates run from one-fifth to one-third – anywhere from 9 to 15 million people.

So, if you take away:
• 10 million non-citizens,
• 9 million who earn over $75 thousand a year, and
• 9 to 15 million eligible for existing government health plans …

You are left with 12 to 18 million uninsured. That’s just 4 to 6 percent of the population.

If THAT’S all we really need to address, why are we thinking of turning the whole system upside down? Wouldn’t it make more sense to simply adjust existing programs – for example, to expand Medicaid eligibility appropriately?

It’s also important to remember that the uninsured are NOT without health care. The present system, with all its flaws, still provides access to health care through a vast network of hospitals, clinics, and charitable organizations.

The National Center for Policy Analysis estimates that the uninsured get an average of $1,500 worth of health care each year.

Families USA estimates that in 2008, the uninsured received some $116 billion worth of health care – most paid for by government, charities, and by the uninsured themselves – presumably those who can afford it.

However, a little over one-third of the care for the uninsured is “uncompensated”—that is, either absorbed by providers or shifted to others.

In fact, one of the biggest flaws in our present system – the fast-rising cost of health care – can be attributed in part to the way the system shifts the cost of caring for the uninsured to people with private or employer-paid insurance.

“Cost-shifting” is also how doctors and hospitals try to compensate for the paltry reimbursements they receive from government programs like Medicare and Medicaid, which often pay as little as half what private insurance companies do.

Rampant cost shifting is the cause of those notorious “eight-dollar aspirin tablets” we hear about.

More importantly, cost shifting has also led to the closing of many city-center hospitals with a high percentage of patients who are uninsured or are covered by low-paying government programs. These hospitals can’t cost-shift enough to stay afloat.

The Hawaii Medical Center—formerly St. Francis—is a classic example. It’s in bankruptcy because, fundamentally, it primarily serves Medicare and Medicaid patients at unsustainably low reimbursement rates.
What about another common belief – that it's the uninsured who are overtaxing the nation’s emergency rooms?

According to the National Center for Policy Analysis, the bigger problem is the people who ARE insured – BY THE GOVERNMENT.

The low fees from programs like Medicare and Medicaid have caused many physicians to decline to serve those patients – who then turn to emergency rooms, which are obliged by federal law to treat them.

In any case, our President, much of Congress, and much of the media are paying no attention to inconvenient facts like these. Instead of trying to fix a problem of manageable proportions, they’re focused on that bogus 45.7 million figure and are shooting for the moon.

Even though they deny it, many doctors and I are convinced the President and congressional leadership are aiming for a very expensive, “single-payer,” national health care system.

The President’s protestations to the contrary, such a universal system will have to be paid for by increasing taxes and rationing health care benefits.

Having practiced medicine under both the free market and partially government-controlled systems – Medicare and Medicaid – and being still involved in health care as chairman of the Colorado Neurological Institute, I am certain that a national system is the wrong way to go.

Why? Because it is a blunt instrument that will create more problems than it will solve.

That’s why I think it makes more sense to focus on how to provide health care coverage for the 12 to 18 million who need help than to impose a massive bureaucracy on the great majority for whom the current system is working.

Let’s now look at the problems with the government-dominated, “single-payer” system the President and Congress are pushing.

I’ll begin by reminding you of an old saying – “You can have it CHEAP, FAST, or GOOD – choose two.”

The point is, you can’t get all three. If you want something cheap, it may also be fast, but it WON’T be also fast AND good. And, if you want something that’s both fast and good, it WON’T be cheap. That’s life!

The idea that health care can be good, fast (that is, timely), AND cheap is a mirage. It can APPEAR to be cheap if it’s paid for not by patients, but by insurance companies or by taxes – Washington’s favorite solution.

But then we’d all better hang onto our wallets.

Think about it. Has there ever been a government program that didn’t grow and cost far more than predicted?

This is just what has happened with Medicare, Medicaid, and SCHIP (the State Children’s Health Insurance Program).

Medicare and Medicaid alone now consume more than a third of the federal budget and are both running out of money—at an accelerating rate.

As recently reported by the *New York Times*, Medicare will go broke in just eight years, two years sooner than projected last year and about 20 years sooner than predicted as recently as 2002.

Just three weeks ago, Douglas Elmendorf, Director of the Congressional Budget Office, testified saying, “The federal budget is on an UNSUSTAINABLE path – meaning that federal debt will continue to grow much faster than the economy over the long run.”

He said most of the spending growth will come from Medicare and Medicaid, and warned, “If current laws do not change, federal spending on Medicare and Medicaid combined will grow from roughly 5 percent of GDP (Gross Domestic Product - the total value of all the goods and services produced nationwide in a year) today to almost 10 percent by 2035 and to more than 17 percent by 2080.”

Does anyone think adding a universal government health insurance program would do anything but further accelerate this
ruinous spending?

Einstein is said to have defined insanity as “doing the same thing over and over again and expecting different results.”

So I am entirely confident in predicting that, if enacted, a government health care program will disastrously bleed the nation’s treasury, suck dollars from taxpayers’ wallets, and sap our economic strength.

It will NOT lower costs. It will only attempt to hide them, which is what happens when taxpayers foot the bill. That encourages people to think some other guy is paying for it. But we all will.

Of course, there IS a way for the government to actually cut dollar costs. And that is to deliver less. In plain English, that’s called RATIONING.

Rationing is sometimes thinly disguised as the slow speed of health care delivery, the hallmark of the much-ballyhooed government-run systems in Canada, Great Britain, and most of Europe. Let me give you some examples.

According to a 2005 report by the Canadian Institute for Health Information:

• 25 percent of Canadians waited six or more days to see a doctor when sick.
• The median wait for a knee replacement was seven months.

But that’s just the beginning. The Fraser Institute, an independent Canadian research organization, produces an annual study titled: “Waiting Your Turn – Hospital Waiting Lists in Canada.”

Here are some statistics for 2008:

• Average waiting time to see a specialist after referral by a general practitioner – 8.5 weeks.
• Average waiting time between specialist consultation and treatment – another 8.7 weeks.
• Total average waiting time between referral to a specialist and the beginning of treatment – 17.3 weeks – four months!

The 2008 Fraser Institute report included the median wait times for several common imaging procedures:

• The CAT scan wait – 4.9 weeks
• The MRI wait – 9.7 weeks
• The ultrasound wait – 4.4 weeks

Two months ago, I had an encounter with the American health care system that puts Canadian wait times in perspective. One Friday morning, I woke up with pain in my upper abdomen. On Monday, I called my doctor, a general practitioner, who squeezed me in that morning. I then had blood tests, an ultrasound scan and, when those failed to identify the problem, a CAT scan, which pinpointed it. Treatment was begun the same day – five days after I first called my doctor.

I hate to think how things would have gone had I been a Canadian. I’d have waited a month for the ultrasound, and might be getting the CAT scan around now. Treatment would still be over the horizon. The pain would have turned into a nightmare, and if the condition were serious, I might be six feet under by now.

Delays like those I just described cause frustration, pain, and suffering. They allow diseases to progress, which makes them harder and costlier to treat. The number of people who die while languishing on a waiting list cannot be trivial.

Why am I so sure? Because in health care, speed is often the key to better outcomes and survival rates. It also lowers costs.

The largest international survey ever done on cancer survival rates showed that in the United States, 66 percent of men and 63 percent of women are alive five years after diagnosis – the world’s highest survival rate.

Compare that to 45 percent for men and 53 percent for women in Great Britain, which has had universal health care for half a century. Think about that!

In the U.S., two-thirds of cancer patients are survivors; in Britain, it’s just half.

Does the much poorer cancer survival rate in a nation with universal health care have anything to do with that system’s
inevitable tendency to ration health care? Absolutely. The predictable result of health care supply that falls short of demand is long lines, long waits … and the death of those who run out of time.

Let’s look at another example – this one provided by the same Dr. Gratzer I mentioned before. In his book, he summarizes research on breast cancer survival.

He writes, “Women who get breast cancer in Europe are four times as likely to be diagnosed AFTER the tumor has spread than women in the United States.”

This leads to a striking difference in mortality, that is, the percentage of those who die of the disease divided by the number of those diagnosed. In the UK, the breast cancer mortality ratio is a dismal 48 percent. This is almost twice what we have in the United States, 25 percent, thanks to early diagnosis.

Now, in the interest of full disclosure, I have to tell you that the breast cancer mortality ratio in France, Germany, and Canada – all of which have government health care – is not as bad as Great Britain’s 48 percent. In France it’s 35 percent, Germany 32 percent, and Canada just 28 percent.

But none of these is as good as the 25 percent in our country.

I’m not sure why Canada, with all the waiting built into its system, does nearly as well as the United States in this area – perhaps its government gives higher priority to mammography screenings than to other procedures. And some Canadians come here for treatment. In fact, many do.

But I feel certain that Canada’s relative success in this area comes in spite of, not because of, its universal health care system.

If you think about it, low speed is the answer to high cost in a government-run system with a limited budget. Again, it’s simply RATIONING.

Earlier this year, the New York Times quoted Treasury Secretary Timothy Geithner as saying the only way to keep Medicare solvent is to control runaway growth in health care expenditures.

That’s a great idea. But just how DO you “control runaway growth”? Well, you can try squeezing doctors, hospitals, and pharmaceutical manufacturers, but that won’t get you very far. However, it will drive many more doctors out of practice, close more hospitals, and greatly slow the astonishing advances of American pharmaceutical makers, who lead the world in conquering a host of deadly diseases.

So how else might you “control runaway growth”? The same way they do it in Canada, England, and Europe – RATIONING by limiting facilities, limiting authorized procedures, denying care to the “unqualified” elderly … long lines, long waits … and the death of those who run out of time.

You don’t have to go abroad to see this. Right here in the U.S., rationing is already the norm in the Department of Veterans Affairs health care system. If that’s how the government treats our veterans, how do you suppose it will treat you and your family, especially in your golden years, when most people incur the bulk of their lifetime medical expenditures?

If anyone thinks rationing isn’t what the administration has in mind, listen to Betsy McCaughey, former Lieutenant Governor of New York and now chair of the Committee to Reduce Infection Deaths. In a Wall Street Journal article a few weeks ago, she wrote as follows:

“Slipped into [February’s stimulus package] was substantial funding for COMPARATIVE EFFECTIVENESS RESEARCH, which is generally understood as code for limiting care based on the patient’s age.”

Under the Comparative Effectiveness formula, the cost of a treatment is divided by the number of years the patient is likely to benefit. In Britain, McCaughey wrote, this “leads to denying treatments for older patients who have fewer years to benefit from care.”

In my case, being 75 years old when the average life expectancy is 78, means my government might give me a pretty low denominator and deny me potentially life-saving treatments. Welcome to Aldous Huxley’s Brave New World.
Think I’m exaggerating? Just take a look at the health care bill the U.S. House is now considering. Admittedly, it probably won’t be enacted in its current form—if it passes at all—but it contains provisions that not only provide for rationing, but would make it a felony for doctors to give patients treatments beyond those a panel of wise men and bureaucrats deems permissible.

If you paid a doctor to give you or your loved one an extra level of care, you’d both go to jail. To ensure “fairness,” the law would bring everyone down to the same minimal level. If such a principle were applied to automobiles, no one would be allowed to own a Lexus. We’d all be driving stripped-down sub-compact Yugos – or mopeds!

This brings us to the third element in that trio I discussed earlier – CHEAP, FAST, and GOOD. The third element is “good,” otherwise known as QUALITY.

You’ve probably already figured out that a system that is neither cheap nor fast is not going to be good either.

By cutting down people’s use of health care services, rationing exacts a terrible price – more people sick, illnesses lasting longer, and lives ending earlier.

To paint the clearest picture I can … We already know how quickly, cheaply, and well government handles driver’s license renewals, motor vehicle registration, building permits, public education, mail, railroads, immigration, border security, and now the bungled “Cash for Clunkers” program.

As one wag recently put it, “The government couldn’t run a used car program for more than a week, and some of you want them to be in charge of your health care?”

Einstein would question your sanity.

If this is how Washington is going to “reform” health care, it will be a sad day for America.

Fortunately, there are better ways to solve the problems with the current system than to replace it with a leviathan.

Here are the key elements of my prescription:
1. Individual Choice and Free Market Competition
2. Tax and Geographic Equity
3. Personal Responsibility
4. Tort Reform

Let’s start with Individual Choice and Market Competition.

Currently, the patient has very little involvement in the choices and economics of health care. If patients – that is, customers – were involved just as they are for other goods and services, providers would compete on the basis of price and the level of service. Generally, prices would fall and service improve.

If you don’t believe it, just look at Lasik, the laser procedure to correct nearsightedness. It’s rarely covered by insurance, and, as more and more providers have entered the market, prices have fallen sharply.

When my son, Chuck, had Lasik surgery about 10 years ago, he paid $3,500 per eye.

If you Google Lasik today, you’ll see offers like these:
“$299 per eye,”
“$0 Down, No Interest!” or
“Compare Quotes – Fast, Easy, Free!”

The same is true in cosmetic surgery, which is also rarely covered by health insurance.

“Great,” you may say, “but insurance covers most doctor visits and medical procedures, so the cost to the patient is just a small co-pay. How do you involve patients without removing the insurance intermediary, and if you do remove the insurers, how will people pay their medical bills, which are so terribly expensive?”
You do it by making Health Savings Accounts universally available. Here’s how it would work.

Instead of taking employer-provided health care insurance, as we do now, individuals could ask employers to give them the same amount of money the employers now spend on their insurance coverage. This would not be cash in hand, but money deposited into each individual’s Health Savings Account.

Like the health benefits insurance employees now receive, this money would be tax-free. It could be spent only for health care – say with a debit card that taps into the tax-free Health Savings Account.

People would use this money for ordinary expenses – visits to the doctor, immunizations, routine tests, most prescriptions, and so on.

What about big expenses, like a stay in the hospital or that CAT scan I had? The Health Savings Account probably couldn’t cover those. But it could cover the low cost of a high-deductible catastrophic insurance plan, which would kick in whenever you incur a large medical expense.

For most people, these don’t occur very often, which is why such coverage is affordable. The higher the deductible, the cheaper the insurance policy – just like your auto insurance.

If you want a plan with a low deductible that covers routine medical expenses, you’d pay a lot more. But that would be your decision, not a government bureaucrat’s.

With a high deductible, where you pay for routine expenses with your own money, you’d often shop around, just like Lasik patients do. Just like I would have done for my diagnostic tests.

This would put people back in charge of their own health care, just like in the old days when doctors made house calls. It would rebuild the free market in health care, reintroduce price competition, eliminate a ton of paperwork, and get the insurance companies out of the middle of most medical decisions.

So that’s the first principle – Individual Choice and Free Market Competition.

How did we get away from that in the first place? It goes back to World War II, when we had wage and price controls. Employers couldn’t reward workers with raises, but thanks to a ruling by the IRS, they could provide health care insurance, tax-free to the employee and credited as a business expense to the employer. An innocent beginning, but it has grown into a monster.

And that brings us to the second principle, Tax and Geographic Equity.

Our current health care insurance system does not apply to everybody. Of all those insured, nearly half – 45 percent – are covered by a government public health program – notably Medicare, Medicaid, SCHIP, Federal Employees Health Benefits Program, Veterans Health Administration, Military Health System, Indian Health System.

Everyone else who wants health care insurance pays for it. But not everyone gets it tax-free.

• Those who get insurance from their employers have a big tax-free benefit.
• The self-employed must pay for it themselves out of their own pockets with after-tax dollars.

That is a fundamental injustice.

The solution: Give people who pay for their own health care a tax deduction for those expenditures – and allow the self-employed to contribute to Health Savings Accounts with pre-tax earnings.

Alternatively, employer-provided health benefits could be treated as taxable income and overall tax rates reduced so as not to increase anyone’s tax burden.

Unfortunately, in the current heated atmosphere, politicians on both sides of the aisle like to terrify people by saying that the other guys want to tax your health care. Nobody’s talking about cutting tax rates in the event health care is taxed.
The subject of Tax Equity raises another issue – Geographic Equity: where people live. Right now, every state has a different set of health insurance regulations, and it’s crazy.

For example, New Jersey requires insurers to cover a wide range of procedures and care, such as in-vitro fertilization, chiropodists, and children until age 25. In 2007, the cost of a standard health insurance policy for a healthy 25-year-old New Jersey man averaged $5,580.

A standard policy in Kentucky, with many fewer government mandates, costs about one-sixth of that, $960.

This should be changed so anyone in any state can buy the health plan that best fits their needs. Lack of interstate competition removes pressure to keep costs down.

In Hawaii, thanks to our challenging regulatory environment, we have relatively few health insurers, and employers are not allowed to fund Health Savings Accounts for employees.

We should get state governments out of regulating health insurance, improve self choice, increase competition, and have one set of uniform federal regulations to help make health insurance portable. No one should have their coverage cancelled, or have to change insurance or switch doctors if they change their job.

A third principle is Personal Responsibility.

People who put themselves at risk should have to bear the higher long-term costs of their medical care and not shift it to others. Currently, smokers, heavy drinkers, drug users, and the obese don’t pay more for health insurance, even though they usually require much more medical care.

For example, the Centers for Disease Control & Prevention recently reported a study that showed that in 2006, the obese spent 42 percent more than people of normal weight on medical care. The nation’s total cost of treating obesity-related diseases in 2008 is estimated at $147 Billion. Yet, at present, people who live healthily subsidize the health insurance of those who don’t.

And we wonder why health insurance is expensive!

The last of my four basic health care principles, with all due respect to the lawyers in the room, is Tort Reform.

Medical malpractice lawsuits add a tremendous cost to the nation’s health care bill. But thanks to generous campaign contributions by America’s trial lawyers, Congress and state legislatures have repeatedly failed to pass meaningful limits on medical malpractice awards. This has led to a sharp increase in the price of malpractice insurance.

According to the Insurance Information Institute, in jury trials, malpractice jackpots – I mean awards – averaged an astonishing $3.83 million per case.

Nationwide, medical malpractice tort costs total more than $30 billion a year.

But that’s not all. To find the true cost, we need to add the cost of all the extra procedures and tests done by doctors and hospitals practicing “defensive medicine.” Who pays for all this? Everybody. It’s a significant part of the high cost of health care.

Finally, in addition to the four basic principles in Dr. Kelley’s health care prescription, there are a few other things we must do.

We must fortify the system of public health care clinics. Clinics that provide “free” medical care to those who cannot afford to pay for it are a valuable part of our health care system.

Unfortunately, in recent years, public funding of free health care programs has decreased and access to these clinics has become complicated. Indigent patients have been pushed into a web of lower-cost insurance programs that enable them to receive care at private medical offices and clinics.

While it’s an excellent idea to provide low-cost insurance programs to those in need, what many indigent people need even
more than complicated insurance programs, is easy access to high-quality medical care. Strengthening our public health clinics will serve the indigent better, decrease cost shifting, and lower the overall cost of health care.

Finally, we must make sure that government programs, such as Medicare, Medicaid, SCHIP and others, are paying their fair share. This would greatly diminish the problem of cost-shifting and help bring America’s health care bills under control.

There you have it – diagnosis and prescription.

Well, a few prescriptions!

Finally, indulge me for one moment more as I reflect on something a wise man once said:

“My reading of history convinces me that most bad government results from too much government.”

To whom are these words attributed?


I rest my case.