Letter from America: the political economics of US healthcare reform

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Introduction

After two years of campaigning, 'yes we can' became 'yes we did' and there is now a Democrat in the White House, and they also control the Senate and the House of Representatives. Barack Obama could be forgiven for wondering if the lustre has worn off his recently acquired prize and might even recall the words of John F Kennedy, who admitted that 'when we got into office, the thing that surprised me most was to find things were just as bad as we had been saying they were'. Obama's victory and inauguration speeches were considerably more moderated than his earlier stump speeches and he was careful to draw attention to the inevitable setbacks and defeats that could lie ahead.

There was no mention of healthcare during Obama's victory speech and only passing mention during his inauguration speech despite poignant accounts of his mother's struggle to pay her medical bills while dying of ovarian cancer, and much emphasis on healthcare reform during the earlier campaign. The words of former President, Bill Clinton, indicate the reason – it's the economy, stupid. As Obama was winning the Iowa Caucuses (the first step in the Presidential nomination process), the economy was emerging as the key issue. By the election, the Dow Jones had fallen 4000 points from its peak forcing an unprecedented \$800 billion out of the banking industry.

The new administration's immediate priorities are the economy and energy independence. Healthcare is something Obama promised to attend to 'by the end of the first term'. Previously, Bill Clinton identified healthcare as a major driver behind the burgeoning budget deficit and Obama's team is also linking the burden of healthcare costs on employers with increasing health expenditure

and negative effects on job creation. Commentators such as Noam Chomsky have observed that the changing political priority accorded to healthcare reform is a response not to relatively constant public opinion polls but the increasingly unsustainable financial impact that healthcare costs place on the corporate sector. It is commonly quoted that employer-based healthcare costs can add \$2000 to the cost of manufacturing a motor vehicle in the USA and represents a significant loss of competitive advantage.

Background

The United States of America was founded on the rejection and distrust of government and a belief in the decentralization of political and economic power that results from individual autonomy. These values underpin the modern conservative movement and have been particularly influential over the last three decades. A normative view of healthcare exists as a commodity subject to consumer sovereignty and for which the collectivist approaches adopted by many European nations are antithetical.¹ The 'invisible hand' of the market is the primary mechanism for allocating goods, and government provision is perceived as inefficient, unresponsive and possibly totalitarian.

The conservative perspective has been supported by the free market ideology of Frederik Hayek, Nobel Prize winner Milton Friedman and Kenneth Arrow's work on rational choice. Rational choice holds that advancing the common good is more reliably undertaken by strategies that promote the self-interested decisions made by individuals as individuals cannot be reliably entrusted to act against them.² The difficulty in reconciling individual preferences with group or

collective preferences lead to Arrow's 'impossibility theorem'³ that highlights the fundamental conflict between individual and collectivist approaches to decision-making.

Within this ideological debate lies the issue of whether healthcare is a 'right'. There is a nuanced difference of perception in the US where the concept of a 'right' is centred on protection from government interference, so 'negative rights' are upheld that ensure protection from the harmful actions of others, but protect the 'right to action' of the individual. This is in contrast to 'positive rights' which obligate the actions of others to the benefit of a specific individual ('rights to rewards').

It was on these grounds that critics of Medicare (government-provided healthcare for the over-65s and the disabled) such as Ronald Reagan exhorted people to oppose 'socialized medicine', warning that 'if you don't do this and if I don't do it, one of these days you and I are going to spend our sunset years telling our children and our children's children, what it was once like in America when men were free'. More recently in 2006, California Governor Schwarzenegger vetoed single-payer healthcare favouring a market-oriented scheme (dubbed 'Terminatorcare' by his critics). He did not 'believe that government should be getting in there and should start running a healthcare system' and said, 'I think that what we should do is be a facilitator, to make the healthcare costs come down'. In a similar way, the recurring debate in the UK on the relationship between the state and a welfare society can also be understood in terms individual autonomy.⁵

Libertarians have also warned of the dangers of socialized medicine. Ayn Rand wrote that doctors are not servants of their patients but are 'traders, like everyone else in a free society, and they should bear that title proudly, considering the crucial importance of the services they offer'. As with any good or service, her supporters argue that if its possession becomes by a right, the providers of the service are enslaved, the service is wrecked and the very consumers who require it are deprived. Thus by calling medical care a 'right', libertarians argue that doctors are enslaved and the quality of medical care destroyed. Rand argued that if the people of a country *truly* cannot afford a certain service, for that very reason, neither could the government afford it either.⁶

The healthcare market

The general success of free markets suggests that the US healthcare system should deliver efficient and effective healthcare. No direct measures of the quality of care between countries exist to allow international comparisons. One indirect measure is the level of health employment in a country which can be taken as an indicator for the potential level of healthcare provision. A comparison of OECD countries shows that the USA only buys a 'healthcare provider level' below the OECD average.⁷ Measuring outputs is even more difficult. Either subjective (survey data) or indirect measures (e.g. life expectancy or infant mortality) are used. Treatment amenable mortality⁸ has been suggested but it is not a direct measure of the quality of care and does not adjust for differences in risk factors and morbidity. Socioeconomic factors may influence high level health indices and do not reflect failure of the healthcare system *per se*. Even if only a few comparative indicators are available it can be concluded that there is an absence of evidence that the significant investment in healthcare in the USA is buying better health. Some studies even suggest that the opposite is the case.^{9,10}

Major differences exist between the payment structures in the healthcare systems in the USA and the UK that determine the opportunities to improve their effectiveness and efficiency. The UK operates a 'single-payer' system where the monetary transaction is ultimately between the government (the single payer) and provider. In the UK, the government is also the provider too. The USA has a mixed health economy. It operates a 'third-party payment' system where the third-party payer is the insurance company which is responsible for risk pooling and has government-funded programmes for those on low incomes, the elderly and military veterans. These account for around 46% of healthcare expenditures. Around 15% of the population (around 50 million people) lack health insurance. This headline figure is worthy of closer scrutiny. Around one-third of people in this group are eligible for public programs but not enrolled, one-third could 'afford' health insurance but choose not to purchase it and the remaining one-third probably cannot afford health insurance. Milton Friedman, the Nobel Prize winning economist and key advocate of free markets, noted that

directly administered government systems such as in Canada and Great Britain have important advantages over mixed systems. As the direct purchaser of nearly all medical services they are in a monopoly position in hiring physicians and can limit their remuneration so that with the exception of primary care doctors, physicians earn considerably less than those in the USA. They can also ration care directly – at the cost of waiting lists and public dissatisfaction.¹¹ Indeed, in the UK the recent public protests in opposition to NICE's attempts to restrict funding of specific cancer treatments demonstrates the limitations of social solidarity, the shortcomings of deliberative democracy and the realization of Arrow's impossibility theorem.

In the USA, the tax treatment of private medical expenditures is an important driver of increased healthcare expenditure. Private expenditure is from after-tax income unless insurance is provided by the employer when it is 100% deductible, so that 84% of medical care for the non-elderly is provided this way with consequent 'moral hazard' that contributes to healthcare inflation. Friedman noted that the mixed system despite offering advantages in accessibility results in higher costs than systems based on wholly individual or collective choice. He suggested that medical care should be re-privatized by eliminating most third-party payment and that the role of insurance ought to be to protect against major medical catastrophes.

Instead of a single-payer system Friedman proposed a return to free-market principles through 'medical savings accounts' where employers place a specific amount in a medical savings account for each employee. Friedman recognizes that vested interests resulted in a 'tyranny of the status quo' that made his solution politically non-viable though it might be used to gauge the direction of movement of future reforms.

Other economists have been more skeptical. Alain Enthoven identified the problems of free riders, biased risk selection and segmentation as contributing to market failure. He said, 'free market does not and cannot work in health insurance and healthcare'. He proposed a model of 'managed competition' in the early 1990s which relies on a 'sponsor' to structure and adjust the market for competing health plans, to establish equitable rules, create price sensitive demand and avoid compensated risk selection.¹² His concept was partly incorporated within the reforms proposed

by Hillary Clinton in 1993, as First Lady. Clinton's reforms also called for price controls and global budgets and drew criticism from Enthoven, employers (who were to pick up most of the costs) and republicans. 'Hillary care' failed but exists as a grim reminder of the hazardous nature of healthcare reform.

Other factors have been suggested to account for the observed failure of the healthcare market. An 'asymmetry of information' between the patients and healthcare professionals may act as an impediment to effective consumer choice.¹³ 'Supplier induced demand', where specialty hospitals may drive over utilization of specific services is possibly another factor that drive usage, in addition to the fee for service environment that rewards volume.

Proposals for reform

Obama's mandate does not extend to 'socialized medicine', i.e. single-payer (government-funded) and government-delivered healthcare, and he avoided any damaging association with these during his campaign. His healthcare plan is incremental in nature, builds 'upon the strengths of the US healthcare system' and so acknowledges the political lessons learned from 'Hillarycare'. The main priorities are to increase the number of people who have health insurance, 'modernize' the US healthcare system to lower costs and improve quality, and promote prevention and strengthen public health. He hopes to achieve social solidarity by guaranteeing access to government and private plans because despite an appetite for reform, people are unwilling to give up their current benefits in the interest of collectivism. Although his reforms do not mandate universal coverage they aim to make it a reality to most extents and purposes.

Reducing the visibly high cost of healthcare for the American citizen while widening coverage will clearly be a high political priority. Obama's reforms do not propose 'medical savings accounts' but retain the private insurance model of healthcare, enforcing its uptake through the use of mandates while also expanding government insurance schemes. He claims that his healthcare reform plan will save the typical family up to \$2500 every year through investment in health information technology, improving the prevention and management of chronic conditions, increasing insurance

industry competition and efficiency and making health insurance universal to reduce spending on 'uncompensated care' (emergency healthcare users who do not have insurance, otherwise known as 'free riders').

Eligibility for existing government programmes will be expanded and parents mandated to ensure health insurance coverage for their children. A new government programme similar to Medicare but for those under the age of 65 years who do not have access to an employer plan, or do not qualify for existing government programmes, will be established. This is to be accompanied by a government-run organization to sell insurance plans directly to people without an employer plan or public coverage. Employers will be incentivized to offer health insurance for their employees by a 'pay or play' provision that would otherwise make them contribute toward the cost of a public plan. The overall object is to ensure a mechanism for risk pooling and access across state boundaries. This would strengthen the concept of 'social health insurance' and bring the US system closer to a road most European health insurance systems have gone some decades ago and achieved near universal coverage.

Proposals also include initiatives to improve healthcare quality that go beyond insurance reform and improve the 'delivery system'. These include programmes to promote disease management, coordinated care, patient safety, incentives for excellence, comparative effectiveness reviews and strategies to reduce healthcare disparities. Investment in an electronic health record is also a key component of the Obama health reforms. This will require significant investment and is necessary to facilitate the measurement and improvement of healthcare quality.

Obama estimates his healthcare reform plan may cost up to \$65 billion a year and will be funded by savings and from discontinuing the tax cuts that President Bush introduced for those making more than \$250,000 per year (the result of 'trickle down' or supply side economic policies). Obama also plans to reintroduce catastrophic reinsurance coverage in order to reduce the cost of family health insurance, a policy previously proposed by Senator Kerry and supported in principle by Milton Friedman. These costs are displaced from citizens to government and represent cost shifting rather than genuine cost savings.

The possibility of a US 'NICE' type organization is being mooted even though prescription drug spending accounts for only 10% of total US healthcare expenditure (similar to the UK) and devices account for approximately 6%. Major savings here are unlikely to have a significant impact on per capita spending. The concept of capped global budgets was a key criticism of the Hillarycare reforms so it is doubtful whether drug pricing driven by budgetary constraint as being considered in the UK would be as acceptable in a market-oriented economy such as the US. The initiatives to improve healthcare quality are unlikely to have rapid results and some strategies, e.g. disease prevention for some medical conditions, are not cost-saving and may inflate costs.

Summary

Obama's proposals are incremental and reflect the lesson learned by Hilary Clinton: that small steps are required to address big problems and the fact that there are no simple 'magic bullet' solutions to improving its performance. Lack of universal coverage and uncontained costs lie at the heart of the 'broken' American healthcare system and the current reforms do not offer an easy or assured approach to reducing both in the near term. Despite high expectations, the proposed investments are likely to be inflationary and any cost savings are likely to be longer term. Aspiring to universal coverage is more feasible than reducing costs that require some stakeholders to lose in order for the government to achieve its savings. The economic price attached to the current reforms is considerable and so controversy is inevitable. Nevertheless, Obama's election and his proposed reforms mark a significant political milestone.

It was small step from the free market ideology of Friedman, Hayek and others to the assertion by President Gerald Ford that 'a government big enough to give you everything you want is a government big enough to take from you everything you have' and President Ronald Reagan's later claim that 'government is the problem not the solution'. So long was the shadow cast by this stance that President Bill Clinton subsequently felt obligated to maintain that 'the era of big government is over'. In his November 2008 victory speech President Obama told Americans that 'we have

never just been a collection of individuals', signaling that the political pendulum might be swinging away from the dominant conservative ideology of recent decades that has emphasized the self-interested individual. During his inauguration he went further, to declare that the 'stale political arguments ... no longer apply' and in respect of healthcare that, 'the question today is not whether our government is too big or too small, but whether it works, whether it helps families ... find care they can afford'.

There is increasing consensus that the need for government regulation of the financial markets is a matter of degree. This was given voice by Obama during his inauguration speech when he stated that despite its strengths, 'without a watchful eye, the market can spin out of control'. Though it is not clear how far-reaching health reforms will eventually be, it is reasonable to assume they involve stronger state involvement and the time when the US healthcare system has been an open playing field for free market ideology may now be passing.

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