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A Prescription for American Health Care

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The following is adapted from a speech delivered in Naples, Florida, on February 18, 2009, at a Hillsdale College National Leadership Seminar.

I'll start with the bad news: When we get through the economic time that we're in right now, we're going to be confronted with an even bigger problem. The first of the Baby Boomers started signing up for early retirement under Social Security last year. Two years from now they will start signing up for Medicare. All told, 78 million people are going to stop working, stop paying taxes, stop paying into retirement programs, and start drawing benefits. The problem is, neither Social Security nor Medicare is ready for them. The federal government has made explicit and implicit promises to millions of people, but has put no money aside in order to keep those promises. Some of you may wonder where Bernie Madoff got the idea for his Ponzi scheme. Clearly he was studying federal entitlement policy.

Meanwhile, in the private sector, many employer-sponsored pension plans are not fully funded. Nor is the federal government insurance scheme behind those plans. We have a potential taxpayer liability of between 500 billion and one trillion dollars for those private pension plans, depending on the markets. And on top of that, roughly one-third of all Baby Boomers work for an employer who has promised post-

retirement health care. As with the auto companies, almost none of that is funded either. Nor are most state and local post-retirement health benefit plans. Some California localities have already declared bankruptcy because of their employee retirement plans and the first of the Baby Boomers is still only 63 years old.

What all this means is that we're looking at a huge gap between what an entire generation thinks is going to happen during its retirement years and the funds that are there—or, more accurately, are *not* there—to make good on all those promises. Somebody is going to be really disappointed. Either the Baby Boomers are not going to have the retirement life that they expect or taxpayers are going to be hit with a tremendously huge bill. Or both.

The Mess We're In

How did this crisis come about? After all, the need to deal with risk is not a new human problem. From the beginning of time, people have faced the risks of growing old and outliving their assets, dying young without having provided for their dependents, becoming disabled and not being able to support themselves and their families, becoming ill and needing health care and not being able to afford it, or discovering that their skills are no longer needed in the job market. These risks are not new. What is new is how we deal with them.

Prior to the 20th century, we

handled risks with the help of family and extended family. In the 19th century, by the time a child was nine years old, he was usually paying his own way in the household. In effect, children were their parents' retirement plan. But during the 20th century, families became smaller and more dispersed—thus less useful as insurance against risk. So people turned to government for help. In fact, the main reason why governments throughout the developed world have undergone such tremendous growth has been to insure middle class families against risks that they could not easily insure against on their own. This is why our government today is a major player in retirement, health care, disability and unemployment.

Government, however, has performed abysmally. It has spent money it doesn't have and made promises it can't keep, all on the backs of future taxpayers. The Trustees of Social Security estimate a

current unfunded liability in excess of \$100 trillion in 2009 dollars. This means that the federal government has promised more than \$100 trillion over and above any taxes or premiums it expects to receive. In other words, for Social Security to be financially sound, the federal government should have \$100 trillion—a sum of money six-and-a-half times the size of our entire economy—in the bank and earning interest right now. But it doesn't. And while many believe that Social Security represents our greatest entitlement problem, Medicare is six times larger in terms of unfunded obligations. These

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numbers are admittedly based on future projections. But consider the situation in this light: What if we asked the federal government to account for its obligations the same way the private sector is forced to account for its pensions? In other words, if the federal government suddenly closed down Social Security and Medicare, how much would be owed in terms of benefits already earned? The answer is \$52 trillion, an amount several times the size of the U.S. economy.

What does this mean for the future? We know that Social Security and Medicare have been spending more than they are taking in for quite some time. As the Baby Boomers start retiring, this deficit is going to grow dramatically. In 2012, only three years from now, Social Security and Medicare will need one out of every ten general income tax dollars to make up for their combined deficits. By 2020—just eleven years down the road—the federal government will need one out of every four income tax dollars to pay for these programs. By 2030, the midpoint of the Baby Boomer retirement years, it will require one of every two income tax dollars. So it is clear that the federal government will be forced either to scale back everything else it's doing in a drastic way or raise taxes dramatically.

I have not even mentioned Medicaid, but it is almost as large a problem in this regard as Medicare. A recent forecast by the Congressional Budget Office—an economic forecasting agency that is controlled by the Democrats in Congress, not by some conservative private sector outfit—shows that Medicare and Medicaid alone are going to crowd out everything else the federal government is doing by mid-century. And that means everything—national defense, energy, education, the whole works. We'll only have health care. If, on the other hand, the government continues with everything else it is doing today and raises taxes to pay for Medicare and Medicaid, the Congressional Budget Office estimates that, by mid-century, a middle-income family will have to pay two-thirds of its income in taxes!

Cleaning Up the Mess

The only sensible alternative to relying on a welfare state to solve our health care needs is a renewed reliance on private sector institutions that utilize individual choice and free markets to insure against unforeseen contingencies. In the case of Medicare, our single largest health care problem, such a solution would need to do three things: liberate the patients, liberate the doctors, and pre-fund the system as we move through time.

By liberating the patients I mean giving them more control over their money—at a minimum, one-third of their Medicare dollars. Designate what the patient is able to pay for with this money, and then give him control over it. Based on our experience with health savings accounts, people who are managing their own money make radically different choices. They find ways to be far more prudent and economical in their consumption.

As for doctors, most people don't realize that they are trapped in a system where they have virtually no ability to re-price or re-package their services the way every other professional does. Medicare dictates what it will pay for, what it won't pay for, and the final price. One example of the many harmful effects of this system is the absence of telephone consultations. Almost no one talks to his or her doctor on the phone. Why? Because Medicare doesn't pay a doctor to talk to you on the phone. And private insurers, who tend to follow Medicare's lead, don't pay for phone consultations either. The same goes for e-mail: Only about two percent of patients and doctors e-mail each other—something that is normal in every other profession.

What about digitizing medical records? Doctors typically do not do this, which means that they can't make use of software that allows electronic prescriptions and makes it easier to detect dangerous drug interactions or mistaken dosages. Again, this is something that Medicare doesn't pay for. Likewise patient education: A

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great deal of medical care can be handled in the home without ever seeing a doctor or a nurse—e.g., the treatment of diabetes. But someone has to give patients the initial instruction, and Medicare doesn't pay for that.

If we want to move medicine into the 21st century, we have to give doctors and hospitals the freedom to re-price and re-package their services in ways that neither increase the cost to government nor decrease the quality of service to the patient.

In terms of quality, another obvious free market idea is to have warranties for surgery such as we have on cars, houses and appliances. Many are surprised to learn that about 17 percent of Medicare patients who enter a hospital re-enter within 30 days—usually because of a problem connected with the initial surgery—with the result that the typical hospital makes money on its mistakes. In order for a hospital to make money in a system based on warranties, it must lower its mistake rate. Again, the goal

of our policy should be to generate a market in which doctors and hospitals compete with each other to improve quality and cut costs.

We won't be able to make any of this work in the long run, however, unless we pre-fund the system. Today's teenagers are unlikely to receive medical care during retirement if they must rely on future taxpayers, because taxpayers of the future are unlikely to be agreeable to living in poverty in order to pay their elders' medical bills. This means that everyone must start saving now for post-retirement health care. I would propose that everyone in the workforce put a minimum of four percent of his or her income—perhaps two percent from the employer and two percent from the employee—into a private account, invested in the marketplace, that would grow through time. These private accumulations would eventually replace taxpayer burdens.

In summary, if health care consumers

are allowed to save and spend their own money, and if doctors are allowed to act like entrepreneurs—in other words, if we allow the market to work—there is every reason to believe that health care costs can be prevented from rising faster than our incomes.

The Market in Action

Let me offer a few examples of how the free market is already working on the fringes of health care. Cosmetic surgery is a market that acts like a real market—by which I mean that it is not covered by insurance, consumers can compare prices and services, and doctors can act as entrepreneurs. As a result, over the last 15 years, the real price of cosmetic surgery has gone down while that of almost every other kind of surgery has been rising faster than the Consumer Price Index—and even though the number of people getting cosmetic surgery has increased by five- or six-fold.

In Dallas there is an entrepreneurial health care provider with two million customers who pay a small fee each month for the ability to talk to a doctor on the telephone. Patients must have an electronic medical record, so that whichever doctor answers the phone can view the patient's electronic medical record and talk to the patient. This company is growing in large part because it provides a service that the traditional health care system can't provide. Likewise, walk-in clinics are becoming more numerous around the country. At most of these clinics a registered nurse sits in front of a computer terminal, the patient describes his symptoms, and the nurse types in the information and follows a computerized protocol. The patient's record is electronic, the nurse can prescribe electronically, and the patient sees the price in advance.

We're also seeing the rise of concierge doctors—doctors who don't want to deal with third-party insurers. When this idea started out in California, doctors were charging 10-15 thousand dollars per year. But the free market has worked and the price has come down radically. In Dallas, concierge doctors charge only \$40 per employee per month. In return, the patient receives access to the doctor by phone and e-mail, and the doctor keeps electronic medical records, competes for business based on lowering time costs as well as money costs, and is willing to help with patient education.

Finally, consider the international market for what has become known as medical tourism. Hospitals in India, Singapore and Thailand are competing worldwide for patients. Of course, no one is going to get on a plane without some assurances of low cost and high quality—which means that, in order to attract patients, these hospitals have to publicize their error rates, their mortality rates for certain kinds of surgery, their infection rates, and so on. Their doctors are all board-certified in the United States, and they compete for patients in the same way producers and suppliers compete for clients in any other market. Most of their patients come from Europe, but the long-term threat to the American hospital system can't be denied. Leaving the country means leaving bureaucratic red tape behind and dealing instead with entrepreneurs who provide high-quality, low-cost medicine.

As these examples suggest, liberating the medical market by freeing doctors and patients is the only way to bring health care costs under control without sacrificing quality. Continuing on our

current path—allowing health care costs to rise at twice the rate of income under the aegis of an unworkable government Ponzi scheme—is by comparison unreasonable. ■



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