Appropriate Health Insurance

A Preservation Institute Policy Study

The Natural Environment : The Social Environment

The Preservation Institute
2140 Shattuck Ave, Suite 2122
Berkeley, CA 94704

http://www.preservenet.com

Since the 1970s, social critics have used modern health care as an example of the central failing of the technological economy. Patients are totally dependent on doctors and other experts, whose technical knowledge lets them make medical decisions that are beyond the understanding of ordinary people.

Social critics sympathetic to the appropriate technology movement, such as Ivan Illich, showed this dependency on high-technology treatment no longer makes sense. Today, we are spending so much on health care that many medical treatments are wasteful and ineffective. Changing people's personal behavior is now the key to improving health.

This radical critique of consumerism has had an important practical influence on health care. Critics showed that many high-technology treatments are useless. As a result, there has been some movement to shift to lower-technology health care-for example, to replace hospital births with births attended by midwives- and there has been a major effort to control health-care costs by eliminating unnecessary procedures. Critics showed that spending more on medical care is not as important as things that people can do for their own health. As a result, life expectancy has increased significantly since 1970, primarily because many Americans quit smoking, started exercising, and started eating healthier diets.

Yet these critics focused on our technocratic medical care and ignored our technocratic system of health insurance. As a result, the appropriate technology movement has not had any effect on the national debate over health insurance reform. From the days of Carter's proposals for compulsory national health insurance in the 1970s to the debate over Clinton's plans for managed care in the 1990s, the left has continued to back plans that create massive centralized insurance organizations that would make ordinary people more powerless and dependent.

This study shows that to rein in our health care system, cut costs, and improve health, we need not only appropriate health care technology but also appropriate health insurance.

The Post-War Model

Health care costs soared in post-war America when we adopted a system of cost-plus insurance. Because the nation was flush with affluence and had endless faith in technology, we built a health insurance system based on two assumptions: that decisions about health care were complex technical questions which only medical experts could

understand, and that we have an obligation to pay for any treatment that the experts say will improve health.

Under the post-war system of cost-plus insurance, once the doctor determined that a treatment was needed, its cost was passed through to the insurance company. The more the treatment cost, the more the insurance company paid. Both the provider and the consumer of health-care ignored costs. The patient never saw the bills and had no incentive to choose less expensive alternatives.

Health-care costs rose most dramatically after 1965, when most insurance plans begin to pay for doctor bills as well has hospital bills. Medicare, the national health plan for the elderly adopted in 1965, covered doctor bills in order to buy off doctors who were opposed to this new form of "socialized medicine." Before this time, most health insurance covered only hospital bills, which ordinary people could not pay, and not doctors' bills, which most people could pay for themselves. But after 1965, most health plans imitated Medicare, extending the cost-plus method of payment to cover all the medical bills of most Americans.

The idea that we should give everyone a blank check to pay for health care was considered very high-minded and idealistic. People argued for this policy by saying that health care is a necessity, but we do not pay for other necessities (such as food) in this way. The difference is that we consider ordinary people competent to choose their own food but incompetent to make decisions about their own health care. Because it involves complex technical questions that are sometimes a matter of life and death, health care is an extreme example of consumerist dependency: people are eager to have technological organizations make their decisions for them.

The post-war system of cost-plus payments and the post-war faith in modern technology, led to a huge increase in spending on health care, much of it for treatments that are useless. Once consumers were covered, they had no incentive to cut costs by avoiding useless treatments or by choosing simpler forms of health care when they are available.

It came to be considered less than decent for an American to be born at home: by the 1960s, virtually all of our births occurred in hospitals. Yet the United States has a higher infant mortality rate than Sweden and the Netherlands, where most births are handled at home by midwives. A study done in Santa Cruz, California, showed that home births, attended by lay midwives whose training was a year of apprenticeship, had fewer complications than hospital births, attended by highly educated doctors and nurses. "Hospital births are organized around doctors' schedules," one of the researchers concluded. "In the hospital, there is pressure to shorten labor, to give anesthesia, and to use forceps." Midwives, precisely because they cost less, can have more patience with the natural process of birth, and they are more successful than doctors in cases where prenatal examination shows that the birth will proceed without complications.

It also came to be considered less than decent to die at home. The modern consumer dies in a hospital, surrounded by tubes, machines, doctors, and technicians, rather than at home, surrounded by friends and family. Often there is no treatment that will lengthen

useful life. The hospitals are filled with expensive machines whose main function is to prolong suffering and to maintain life in a vegetable state after all hope of recovery is gone.

There are also useless—and positively harmful—treatments from cradle to grave. In post-war America, for example, doctors got into the habit of yanking out a patient's tonsils at the first sign of trouble: by the 1970s, it was estimated that 90 percent of all tonsillectomies were unnecessary, and the procedure had become a national scandal. Even worse, in post-war America, doctors routinely used X-rays in their regular checkups of young children, which have little value as a diagnostic tool but do cause cancer.

Routine tonsillectomies and x-rays became notorious, and both have been controlled. But they were replaced by a new battery of unnecessary procedures.

Studies during recent decades have shown that about 25 percent of medical procedures in the United States are unnecessary or harmful. In the 1980s, the Rand Corporation released the results of studies that began by developing a national consensus among doctors about when certain procedures were necessary, and then looked at thousands of case records to see how many inappropriate procedures were performed. Value Health Sciences, which included some members of the Rand research team, did more detailed follow up studies of certain high-volume procedures. All of these studies ignored cost and defined a procedure as inappropriate only if its benefit to the patient was outweighed by its risk to the patient. Among their findings:

- The Rand Corporation found that, of the 386 coronary bypass operations that it studied, 14 percent were inappropriate.
- The Rand Corporation found that, of the 1,300 operations to remove athero-sclerotic plaque from the carotid artery of elderly patients that it studied, 32 percent were inappropriate.
- Value Health Sciences found that 27 percent of all hysterectomies are inappropriate. This is the second most common major surgical procedure in the United States. Gynecologists regularly recommend hysterectomies for fibroids, uterine prolapse, and heavy bleeding, though there are less dangerous treatments for all of these.
- Value Health Sciences found that about half of all Cesarean sections performed in the United States are inappropriate. This is the most common surgical procedure in the United States. American obstetricians routinely perform Cesarean sections for "prolonged labor"—which means that they are done to save the doctor's time. Hospitals that have deliberately set out to avoid unnecessary Cesarean sections have reduced the rate by at least half, with no added risk to mothers or babies.

Because their risks were greater than their benefits, these medical procedures actually harmed the health of the average patient who was subjected to them. Many other technologies are costly but useless.

For example, specialists have become more common than family practitioners in the United States. Though the National Academy of Sciences urged in 1976 that we shift back to training family doctors in order to cut costs and improve care, the use of specialists continued to grow. Today, about two-thirds of American doctors are specialists, and about three-fourths of recent medical school graduates are specialists-compared with about half in other industrial nations. Specialists earn much more than primary-care doctors, but a recent study of people who get their usual care from both, found that specialists put more patients into the hospitals, prescribe more drugs and perform more tests, but that general practitioners are just as successful in protecting their patients' health.

Likewise, comparisons of different areas in the United States by Dr. John Wennberg, a professor of family and community medicine at Dartmouth Medical School, showed that there are tremendous variations in expenditures without any benefit to the locations that spend more. For example, Wennberg found that

- About 70 percent of the children who grew up in Stowe, Vermont, had tonsillectomies by the time they were 15 years old, but only 10 percent of the children who grew up in Waterbury, Vermont, had tonsillectomies by that age.
- About 50 percent of men in Portland, Maine, had prostate surgery by age 85, but only about 10 percent of the men in Bangor, Maine, had prostate surgery by that age.
- Heart surgery was about twice as common in Des Moines, Iowa, as in Iowa City.
- Boston had about 30 percent more hospital beds per capita than New Haven, Connecticut, but both cities had about 85 percent of hospital beds filled at any time. Though doctors in the two cities were not aware of the difference, Wennberg concluded that the increased availability of hospital beds led doctors in Boston to recommend hospitalization more often.

In all these cases and many others, Wennberg found that—except for extremely poor areas, where people lack basic health care—high-use areas had no better health than low-use areas.

Differences among countries are even more dramatic than differences within the United States. The United States spends more than twice as much per capita on health care as the average in the Organization for Economic Cooperation and Development (made up of the world's industrialized nations). Yet, among the 24 countries in the OECD, the United States ranks 21st in infant mortality, 17th in male life expectancy, and 16th in female life expectancy.

Studies that look at individual procedures to see which are unnecessary have estimated that about one-quarter of our health care spending is wasted. But these international comparisons indicate that half of what we spend on health care is wasted—about 7 percent of our total GDP wasted on unnecessary health care.

Yet this waste is happening at the same time that many Americans have no insurance coverage at all and are in danger of going without treatment for serious diseases. Many small businesses are dropping health insurance coverage for their employees because they cannot afford the rising costs.

The Failure of Growth

By the 1970s, it was becoming clear that increased spending on medical care was no longer improving health.

Between the eighteenth and the twentieth century, life expectancy in the West soared because of better living standards and medical care. Average life expectancy in western Europe was between 30 and 40 years in 1700 and is over 70 years today.

But by the mid twentieth century, improvements in life expectancy slowed dramatically. During the late 1950s and the 1960s American life expectancy leveled off at about 70 years, during a time of unparalleled growth in the standard of living and even more rapid growth in health-care spending.

Life expectancy stopped increasing while health-care spending was soaring, because we reached a point where spending more brings less and less significant benefits. In 1860, most people still lacked basic health care. By 1960, most people had the basic medical care that is needed, and most ***increases*** in medical spending paid for ***extra*** treatments that are absolutely useless or even harmful—like the ones we just looked at.

Apart from medical care, it is widely recognized that health improved over the past few hundred years primarily because of the improved background conditions that economic growth made possible: better nutrition, housing, and sanitation. By the 1960s, however, for most Americans, improvements in these background factors had also become trivial to the point of uselessness or had even become harmful:

- Higher food production helped to improve health over the past few centuries, but further increases in the food supply during the past few decades have not improved the average American's health. On the contrary, overweight and excessive meat consumption now harm our health.

- During the nineteenth and early twentieth centuries, public health experts said that the move to streetcar suburbs was reducing the risk of infectious disease, because their population densities were much lower than older urban tenement districts. By the 1960s, Americans were moving to much lower density suburbs built around the automobile: these new suburbs did not reduce the of infection significantly compared with streetcar suburbs, but they did increase the number of automobile accidents, which became a major new cause of injury and death.

Though economic growth brings health benefits that are less and less significant, it causes threats to health that are very real. Many of today's most common diseases-such as heart disease, cancer, emphysema, obesity, hypertension, and most injuries caused by accidents-are the by-products of economic "progress."

The single greatest cause of death in the United States is heart disease, which increased by 2000 percent between 1930 and 1960, before it stabilized and began falling. This increase was caused by cigarette smoking, lack of exercise (at a time when walking almost disappeared as a form of transportation) and by diets of processed and fatty food—particularly by increased meat consumption.

The second greatest cause of death is cancer. For decades, everyone thought that we could find a cure for this disease if we spent enough on research and development. In 1971, Richard Nixon declared that "the time has come when the same kind of concentrated effort which split the atom [!] and took men to the moon should be turned toward conquering this dread disease," and Congress allocated $2.7 billion to the National Cancer Program. Yet most scientists now agree that this program's main achievement was to show that cancer is more an environmental problem than a medical problem: up to 90 percent of cancer is caused by substances in air, water, food, tobacco, and industrial environments. Apart from cigarette smoking, modern technology itself is the one great cause of this disease.

The third major cause of death is strokes, with similar causes to heart disease.

Among adolescents and children over one year old, automobile accidents are the number one cause of death. Automobile accidents, homicides and suicides are the three leading causes of death among adolescents: though the press emphasizes homicides and suicides, automobile deaths account for about three times as many deaths as either.

During the last few decades, we have learned that we can do more for our health by changing our habits and lifestyle than by spending more money on medical care.

Beginning in the 1970s, life expectancy again began to increase significantly, from the 70 years of the 1950s and 1960s to today's 75 years, because of a sharp drop in deaths from heart disease and strokes. Yet this change was not caused by a higher standard of living or by more medical care. Though by-pass surgery has had some effect, the main cause of the decline in deaths from heart disease was a general trend toward physical fitness: during the 1970s, the number of Americans who exercised regularly doubled, better diets pushed down Americans' blood cholesterol levels by 5 to 10 percent, and middle-aged men smoked 25 percent fewer cigarettes.

Heart disease declined because of individual, personal efforts to be physically fit. Looking back on this change, a 1979 Surgeon General's report concluded that Americans could start a "public health revolution" by changing their habits and diets. One journalist noted that "The report represents an important consensus among doctors and medical scientists. A time has been reached, they say, when people can do far more to improve their health by acting themselves than they can by going to doctors."

Waste More, Want More

Health care costs have risen dramatically: from 5.3 percent of the GNP in 1960 to over 8 percent of the GNP in 1975 to about 14 percent of the GNP today. By the 1970s, it was becoming apparent that most of the increased spending paid for wasteful treatment and that rising expenditures were not improving health, and it has been widely acknowledged ever since that increasing health care costs are a major economic problem.

Of course, there was a reward for using useless or even harmful treatments under the cost-plus system of health insurance. The more doctors or hospitals charged, the more money they earned.

American insurance companies have been trying to control costs for decades by requiring stricter review of recommended procedures to insure that they are necessary, and by denying coverage for some procedures, but they have not dealt with the underlying problem: that cost-plus insurance coverage gives people incentives to consume health care wastefully and to demand even more health care.

As a result, we now have a medical system that combines almost unbelievable waste in some cases with excessively strict rationing in others.

Medicare offers some of the worst examples of waste, because the political power of the American Association of Retired Persons, has made it difficult to implement cost-controls. For example, some people who need monthly kidney dialysis let Medicare pay for an ambulance to take them to the hospital, though it would be just as easy for them to take a cab and would cost only a tiny fraction as much (which they would have to pay themselves). Likewise, some people who cannot cut their own toenails have Medicare pay a podiatrist to do it for them, though going to a manicurist would cost far less money (which they would have to pay themselves).

By contrast, consider a typical case of a man in his forties, who is covered by an insurance plan provided by his employer, is careful about his diet, does not smoke and exercises regularly. Every two years, he goes to a local doctors in his plan for a checkup, and every two years, the doctor tells him that there is nothing wrong with him and people like him keep costs down and make the plan economically feasible for everyone else. But his employer's Dental Health plan covers very few dentists, to control costs, and only one is near enough for him to use. Though he had to travel a half-hour out of his way to get to his office, he had no complaints about this dentist for many years; then the dentist sold his practice to someone else, and on his first visit, the new dentist filled a cavity in a way that trapped food every time he ate—which had never happened to him before. Yet he has no choice but to continue going to this incompetent dentist, the only one in his area who will contract with his Dental Health plan at the rate they are willing to pay.

A bureaucratic approach to controlling health-care costs is bound to create these sorts of contradictions. People will find loopholes in formulas that the bureaucracy uses to control

costs and will take advantage of them to consume unnecessary care. And, because the bureaucracy uses rigid formulas to control costs, people will be forced to use doctors who are marginally competent or to spend an hour and $5 in carfare traveling back and forth to the nearest doctor that their plan covers, even it there is better a doctor right across the street from them who charges only $5 more per visit.

These problems are inevitable as long as we try to control costs without letting the patient take costs into account.

Proposals from the Left

The left has not proposed effective health insurance reforms, because it has never criticized the technocratic model of insurance financing that is at the root of higher costs. Though it has criticized health care technology that makes ordinary people powerless consumers, the left has never applied the same reasoning to the way that health care is financed.

The left's two major proposals for insurance reform, managed competition and single-payer insurance, would both increase centralization and top-down control and the dependency of ordinary people on experts. Both are aimed at expanding coverage rather than controlling costs. Both are relics of an earlier time, when the country did not spend enough on health care or on other services and the old left wanted to mobilize massive bureaucracies to provide these basic services.

Managed Competition

The more moderate proposal from the left is managed competition, the plan proposed by the Clinton administration, whose fundamental idea was to provide universal coverage and control costs by requiring everyone to purchase insurance from a few insurance companies, which would be so large that they could negotiate with health care providers to reduce costs.

This proposal tries to cut costs by helping insurers to cut the cost per treatment, rather than by reducing unnecessary treatments. The only concession that Clinton's plan made to reducing unneeded treatment was excluding mental health care from its coverage: though the plan's backers wanted mental health care to be covered, Clinton removed it as a compromise to hold down costs. The major goal of the plan was to expand coverage—both to people who are not currently insured and to treatments that are not currently covered.

This proposal would have kept third-party, cost-plus payments and the extra demand they induce. By using only the largest private insurance companies, it would have made people more dependent than ever on centralized, technocratic institutions.

This proposal simply reflected the spirit of the modern economy, creating giant technological organizations in order to provide people with more to consume. Its backers had no sense of the failings of economic growth—no notion at all that growing health care expenditures are no longer improving people's health.

Its backers estimated that, by expanding coverage, this plan would have increased health-care costs from the current 14 percent of GDP to 17 percent of GDP. They probably underestimated its cost, but even if we compare their optimistic estimate with costs in the other OECD nations, we can estimate that this play would have wasted 10 percent of the GDP on unnecessary health care.

Single Payer Insurance

The more "radical" proposal from the left is single-payer health insurance, similar to the system in Canada. People would be able to choose their own providers, but one government controlled insurance company would cover all medical expenses.

As in Clinton's plan, the primary goal is to expand coverage. For example, California's Proposition 186, which progressives put on the ballot as a leftist alternative to managed competition, covered all mental-health care, in part as a protest against its being removed from Clinton's proposal to hold down costs. The "radical" left aimed at providing Americans with more health care, regardless of cost—a goal that is far from being a radical challenge to the modern consumer economy.

Despite this unlimited entitlement to consume health care, they claimed that single-payer insurance could keep down costs through global budgeting: the federal government would set a spending limit each year and would not pay more than that for health care in total. Backers of the plan claim that global budgeting has actually led to lower costs in Canada and Europe.

To hold down costs, global budgeting would have to involve either rationing of health care, as in most European countries with similar systems, or long waiting lines for treatment, as in Canada, where the wait for operations is so long that doctors have begun to complain that the delays are becoming a major threat to health.

But it is most likely that global budgeting would simply fail in the United States, because Americans would not let the government limit spending effectively, so that costs would explode. Most European countries are still a bit like an extended family—ethnically homogeneous, many with a monarch and an established church—and people expect the authorities to take care of them but also are willing to accept the limits that the authorities dictate; likewise, the defining difference between Canada and the United States is that Canadians did not throw off the authority of the crown.

Americans would be less likely to accept the authority of people who impose limits on health care spending. Instead, single-payer insurance would probably lead to a public rebellion against rationing and long waiting lists. Because a government health insurance agency would not be insulated from these political pressures, as private insurers are, the most likely result would be runaway federal spending to finance the national health insurance plan.

The people who backed single-payer insurance completely disregarded cost in their political campaign. In all the testimony before Congress on health insurance, progressive "consumer groups" demanded more health care, and only businesses talked about cost. A progressive victory in this campaign would have strengthened the consumerist mentality that is already worse in American than in the rest of the world.

Because we are less likely to bow to the authorities, Americans need a health-care system that keeps costs down by relying on self-control, rather than on external controls imposed by planners. And America is just a few decades ahead of the rest of the world: the same sociological change is happening everywhere, as traditional economies based on obedience to personal authority are replaced with impersonal, technocratic economies. In Europe, the sense that the nation is a sort of extended family where people should obey the authorities, is bound to fade away as the European Community adopts unified social policies managed by faceless EC bureaucrats.

Modernization makes it more and more difficult for the state to control costs by fiat. The alternative is a system that makes people take account of their own health care costs.

Appropriate Health Insurance

While the left kept relying on top-down, bureaucratic approaches, conservatives came up with one important new idea about health insurance, medical savings accounts. Yet the conservative version of this idea would not control costs effectively by eliminating unnecessary treatments because of conservatives' faith in the market and in economic growth.

Personal Empowerment

The most thorough proposal for medical savings accounts is the Cato Institute's plan for health insurance reform, formulated by John Goodman and Gerald Musgrave in their book ***Patient Power***.

This proposal would replace our usual comprehensive health insurance with a combination of catastrophic health insurance and Medical Savings Accounts to pay smaller expenses, in order to reduce waste.

Though rates vary depending on age and location, comprehensive health coverage might cost about $4,500 per year, when a policy with a $2,000 deductible, meant to cover catastrophic expenses, would cost $1,800 per year. Rather than providing comprehensive coverage, employers could save money by providing catastrophic coverage and also giving employees $2,000 a year to put in Medical Savings Accounts, which they could use to pay the deductible: instead of $4,500, this would cost only $3,800 per year for employers and would also leave most employees with extra money in the bank. Insurance with a high deductible costs less overall, because people are less likely to use health care unnecessarily when they are spending their own money.

These Medical Savings Accounts would be a person's own property. People would be allowed to withdraw excess funds from them after they retired, and they could leave the balance to their heirs after they died. They would have an incentive not to spend this money on unneeded care, because they would keep the savings themselves.

Despite their financial advantage for both the employer and the employee, the tax laws make it difficult to create Medical Savings Accounts, because insurance coverage is tax free but cash payments that employees can spend on their own medical expenses are taxable. Employers would no longer save money if they gave employees enough to leave $2,000 after taxes in their Medical Savings Accounts.

Several states have already changed their tax laws to allow Medical Savings Accounts, and employees of companies who use them have saved up to 64 percent of their medical expenses, but changes in the federal tax laws are necessary before they can be widely adopted.

Catastrophic Costs

To cut overall costs significantly, we also need to control spending on catastrophic health care. Medical Savings Accounts to pay the first $2,000 in yearly expenses would cut health care costs for most people but would not affect most money spend on health care. About 10 percent of our population accounts for 72 percent of our health-care spending. These people spend far more than $2,000 per year, so Medical Savings Accounts would not give them any no incentive to hold down costs. Medical Savings Accounts would affect the behavior of 90 percent of Americans and would have an important cultural effect on most Americans by making them more responsible, but they could only cut health-care spending by 10 or 15 percent at the most.

We could give people more responsibility for major expenses by replacing our cost-plus system of catastrophic health insurance with a system similar to the one used for most other forms of insurance, which give the beneficiaries fixed payments to compensate them for specific events. Rather than paying the entire hospital bill for bypass surgery, for example, insurance companies would pay people who need bypass surgery an amount equal to the average cost of the procedure. Hospitals would offer bypass surgery at a fixed price, and consumers would choose among them on the basis of their price and the success rate of the hospital. There would be no need for the complex, itemized bills that hospitals now present to insurers, with costs for individual aspirin tablets, any more than

there is a need for hotels to give people bills that itemize the cost of making their beds and laundering their towels. Ordinary people could compare packages offered by different hospitals, and choose the least expensive procedure at the hospital with the highest success rate. If you choose a plan that costs less than the insurance payment, you could put the extra money in your Medical Savings Account.

Though it is difficult to make this sort of decision when you are ill, it is better for patients and their families to make this choice than to leave it to managers of Health Maintenance Organizations, whose only motive is to cut costs!

Risk Pools

Because of their faith in the free market, Goodman and Musgrave advocate individual payments to employees to let them buy their own insurance, so insurance would automatically be portable: because the insurance belongs to the person rather than to the employee, it would not be lost if the person changes jobs. They also suggest refundable tax credits to let the elderly and poor purchase coverage for themselves, in order to replace the inefficiencies of Medicare and Medicaid.

Liberals have pointed out the defect of this approach: there must be risk pools to make insurance available to everyone. If we everyone got a fixed sum as a tax credit to pay for insurance, there would be a "squeezing out" effect, because insurance companies would offer coverage only to people who are healthy. The 10 percent of Americans who account for 72 percent of our medical spending—mostly elderly people with failing health and also some younger people with special health problems—would find that their tax credit or employee allowance would not buy them insurance.

This objection makes sense, but it should not stop us from changing entire employee or government health-insurance programs immediately so that they offer everyone Medical Savings Accounts and fixed payments for catastrophic health care. If this sort of plan were provided to all of a company's employees or to all Medicare recipients, there would be no squeezing-out effect, and there would be a tremendous reduction of costs.

However, for health insurance reform to move us closer to universal coverage, it must also create risk pools for people who health makes it impossible for them to buy insurance on the market.

Limiting Technology

The greatest objection to conservative proposals for health care reforms, which liberals have not mentioned, is their absolute faith in technology and economic growth.

Goodman and Musgrave claim that we worry about rising medical costs only because employers and government pay these costs and want to reduce them, for example, and they argue that we should think of our increasing medical spending as another feature of

our rising standard of living, as a benefit rather than a cost. They do not see that we have reached the point where the typical American consumes all the useful treatments available and many that are useless as well—which would raise larger questions about the value of economic growth that conservatives would rather ignore.

They want to provide tax deductions for all medical procedures, even for those that are obviously luxuries. For example, they say that people should be able to use the tax-free funds in Medical Savings Accounts to pay for cosmetic plastic surgery, since improving your appearance can help you in your career. By the same reasoning, people should get tax deductions for the money that they spend on Rolex watches and diamond-studded cuff-links, since dressing impressively can help you in your career. Though they do not mention them specifically, Goodman and Musgrave would also allow deductions for penile enlargement and breast enlargement surgery—though it is hard to believe that most people who want these procedures are thinking about their careers!

When we reform the tax system to make it easier for everyone to pay for health insurance, we should also use the tax system to limit unnecessary medical procedures. Just as insurance companies today control costs by limiting which procedures they cover, a system of Medical Savings Accounts and direct payments for catastrophic health care could control costs by limiting which procedures are tax deductible.

The current tax laws are unfair to people whose employers do not provide health insurance.

- If an employer provides insurance, its value is not taxed at all.
- If you are self-employed and must pay for insurance out of your own earnings, only part of the cost is tax deductible.
- If your employer does not provide health insurance and you purchase your own, you do not get any tax deduction.

This tax system is one reason that more people are uninsured, now that fewer work in corporate jobs with health benefits. We should make all health-insurance payments and payments into Medical Savings Accounts deductible from income tax and self-employment tax, to put everyone on the same footing as people whose employers provide insurance.

Yet extending deductions in this way would be very expensive in terms of lost tax revenues if we made all medical care tax deductible, as Goodman and Musgrave recommend, encouraging people to buy more expensive policies. It would cost less if we allowed only expenses for necessary medical procedures to be tax deductible.

The federal government should just do what insurers do when they control costs by deciding which procedures they cover. It should not allow tax deductions for treatments that are not necessary, both treatments that are luxuries—such as cosmetic surgery, unless it is needed to correct damage caused by burns or other disfigurement—and treatments that have not been proven effective.

The tax code could go further, in some ways, than insurance companies have. For example, it could allow tax deductions for hospital births only if prenatal examination has shown that there might be complications, since midwives have been shown to be at least as effective as hospitals for normal births. Insurance companies today could not suddenly stop paying for hospital births, because most people consider them standard. If we were only saying that we do not want to subsidize unnecessary treatment with a tax deduction, not that people can no longer have it at all, it would be easier to change the standard.

By disallowing tax deductions for certain treatments, the government would create a standard that would reduce unnecessary treatments, but it would not arbitrarily impose this standard on people, as insurance companies do today.

It is absolutely necessary to create this sort of standard, in addition to giving people an incentive to reduce costs by making them pay their own bills. No layperson can be expected to evaluate them all and to judge whether each is cost-effective. Even apart from the difficult technical questions involved, people are not going to be able to resist the medical industry's attempts to sell its own products when it is a question of life and death.

People need guidelines to let them know that some treatments are generally considered effective and others are generally considered wasteful. The advantage of using the tax system to send this message is that it does not arbitrarily restrict people who disagree with the common standard. You can have more expensive treatments if you want, but you should not expect other people to subsidize them by making them tax deductible. Some people would try techniques that are not generally considered effective, and sometimes they would surprise the medical economists and prove these techniques are valuable.

Moral Choices

There are also many treatments that are problematic, that are not obviously effective or obviously wasteful. Sometimes there are religious questions: for example, many people have religious scruples about removing life support from terminal patients, even if there is no chance that they will ever regain consciousness. Often, there are questions about cost: should we pay for a procedure that costs $1,000,000 and lets the patient live one extra year in bad health?

In the last couple of decades, we have handed these decisions to a new breed of experts known as medical ethicists. Articles about expensive new medical treatments always quote medical ethicists who pronounce on whether they are cost effective—but no one ever mention the name of the profound moral philosopher who proved that the question of how much a life is worth can be decided quantitatively and that expert ethicists should do the calculations.

These decisions obviously involve moral questions, which people should decide for themselves, not technical questions that they should leave to the experts. We leave them to expert medical ethicists only because decisions about health care are usually made by technological organizations, such as insurance companies and hospitals, rather than by the individuals whose lives are at stake.

The idea that medical ethicists should make these decisions is a huge step backward historically—back beyond the Protestant Reformation, even beyond the moral questioning of the ancient Greeks—to the idea that ethical judgments are the province of an established priesthood whose methods are incomprehensible to ordinary people.

We are moving in this direction because centralized health care systems are imposing the same treatments on everyone. We could return these decisions to individuals, and make it clear that these treatments are controversial by making them partially tax-deductible. Then the tax system would send a message not only that some treatments are generally considered necessary and some are generally considered wasteful; it would also send the message that some are problematic, so you should think hard about them yourself.

Let's look at a few procedures that would fall into the final category:

- If you have prostate surgery, there is a very small chance that you will suffer incontinence or impotence as a result, and on the average, you will live one month less; yet most people who have the operation experience better urine control. This is a case where each person should decide for himself whether weigh the risks outweigh the benefits. After finding that 50 percent of men over 85 in Portland, Maine, and only 10 percent in Bangor, Maine, had had prostate surgery, Dr. John Wennberg produced a video to inform people about the costs and benefits of this procedure, so they can make this decision for themselves. He found that four out of five men prefer to make their own decision.

- Test tube babies cost an average of $72,000 each, according to a 1994 study by Dr. Peter Neumann of Project Hope in Bethesda, Maryland. A single attempt at in vitro fertilization costs $8,000 but does not usually work, and most couples quit before they actually have a child. Is it right to spend this much to produce your own child, rather than adopting, when many children who are already alive need parents and population growth threatens the global environment?

- Many people claim that psycho-active drugs such as Prozac merely restore normal functioning by correcting chemical imbalances in patients' brains, while many others claim that these drugs produce the sort of character that modern society finds desirable. Likewise, many people believe that sex-change operations cure the psychological problems of people who are trapped in a body of the wrong sex, but others argue that it is meaningless to say that you are "really" a woman though you have the body of a man and that this operation merely feeds people's sexual confusions.

Medical advances create many moral dilemmas of this sort, but cost is the most common moral issue that modern medicine raises. How much should we spend to save a life?

The “high-minded” idea that we should spare no expense to save a life is out of touch with reality. For example, it is estimated that, with current technology, doctors could spend $17,000 per person per year simply performing diagnostic tests. That is about half our gross domestic product on diagnostic tests alone—not counting the money that we would have to spend to treat people who were diagnosed as having diseases. And there is no doubt that, if we decided to pay for all available diagnostic test, medical researchers would come up with enough new ones to absorb the entire GDP. All of these tests would do something to save people’s lives, though some might require that we spend millions of dollars over the course of each person’s life in order to increase average life expectancy by one day.

People are “high minded” about sparing no expense only when they are not spending their own money. We can come to grips with this question in more serious way by using a thought experiment. Imagine that you can see your future at age sixty, and you learn that you will die at age seventy unless you spend $400,000 on a treatment that would prolong your life by one year. You have the choice of retiring at sixty and living for ten more years in good health, or of working until you are seventy and saving every cent you earn to pay for an operation that would let you live one extra year in failing health.

This is the sort of question that we are dealing with when we ask which medical treatments are cost-effective. These are obviously decisions that people should make for themselves. Medical ethicists do not have any way of making them for us.

A Practical Proposal

Conservatives and liberals both make important points about health insurance reform, but both have ideological blind spots. If we address the key concerns of both sides and discard the ideological baggage, we can come up with a proposal that could give people responsibility for choosing their own health care, that could control costs, and could even be politically practical.

Liberals recognize the need to control costs and to create risk pools, so even people who are not healthy can buy insurance: for example, there was a proposal in San Francisco to let anyone buy into the city employee’s health plan, joining that risk pool. But the liberal approach to insurance reform suffers from the left’s ideological faith in massive top-down organizations that provide people with services: they want to set up massively centralized insurance systems that deprive ordinary people of all responsibility for choosing their own treatments.

Conservatives recognize the need to let people make their own choices, taking cost into account. But their approach to insurance reform suffers from the right’s ideological faith in the free market: they want individuals to buy their own health care, ignoring the need to create risk pools that include unhealthy people, and they are not willing to control costs by limiting the treatments that are covered.

Perhaps both liberals and conservatives could agree to support one important step toward health insurance reform.

The federal government could open its employees health insurance plan to anyone who wants to buy into it. Federal employees are a large enough risk pool that this plan could absorb everyone under Medicare age whose health makes it impossible for them to buy insurance as individuals.

At the same time, the federal government could convert its employee's health insurance plan to a system of medical savings accounts and fixed payments for specific catastrophic health problems, as described above. To keep down costs, this new system would cover only the treatments that the federal health plan currently covers. The federal government is large enough that providers would tailor their services to respond to these changes.

This reform would be a large step toward extending coverage, which would please liberals, and a large experiment in medical savings accounts, which would please conservatives.

If it was successful, the next steps would be to change the tax laws to allow:

- Full deductibility for health insurance payments, to level the playing field for people who must pay for their own insurance because their jobs do not provide health benefits.
- Tax credits to help pay for health insurance, to make insurance more affordable for lower income people and to give them an incentive to buy insurance.
- Full tax deductibility for money that employers put in medical savings accounts, so they can be used by all health insurance plans.

There is reason to hope that the experiment would be done well, since the federal employee's health insurance plan is the same system that covers the president, congress, and their staffs.

If it succeeded, it could lower health care costs dramatically.

Even more important, by giving people more responsibility for choosing their own health care, it could be part of a larger cultural and economic change, a rejection of consumerism and economic growth that makes people feel more responsible for managing their own lives – and that cultural change is just what is needed to make people change their unhealthy habits and improve their own health.