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EDITORIAL

Myths vs. Realities About Health Care Reform, Part 1

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Almost 15 years ago to the date, I wrote an article for *On The Risk* magazine about health underwriting (risk selection) in which I observed that the Clinton Plan of the time was doomed to legislative defeat, but that the industry nevertheless needed to improve its practices in many areas. While some improvement has taken place, it falls far short of what should have been done within the private sector. This being said, much of what currently passes for 'Health Care Reform' at present is based on false premises that are worth discussing briefly:

1. Advocates of single payer programs in the US tout the experience of other countries as reasons for us to adopt their models. Unfortunately, those advocates appear to misunderstand the true state of things in other countries. The two most glaring examples of this problem are the health care systems in the United Kingdom and Canada. The UK is not a true single-payer only system; a secondary private market with its own network of hospitals and doctors has emerged because many Britons find the queueing and rationing system in the National Health Service system unacceptable, and the limitations of the NHS exist because without them, the system would go under financially. In Canada's case, the provinces have gradually been deconstructing parts of the public system for years. The American system actually serves as a pressure valve for the Canadian system since many Canadians can and do have procedures down here that they can't have in a timely fashion in their own country.

The lesson from the UK and Canada is that the notion that a nationally-paid system produces miraculous savings is a fallacy. The two systems most frequently touted by 'reform' advocates in the US have had severe financial problems and have either formally reinvented the private sector to pick up the slack (as in the UK) or used the American system to pick up part of their health care delivery (as in Canada).

What about the Cuban system then? The reality in Cuba is that doctors can (and sometimes do) make far more money driving a taxi or running a paladar (restaurant) off-shift than they make as doctors. What's wrong with moonlighting, you ask? Think about this for a moment. Would you like your neurosurgeon preparing for your tumor surgery after a long night behind the wheel? Here, too, the 'savings' come at a price. Unfortunately, there doesn't seem to be a good way at present to do an objective study of the quality of services in Cuba. In fairness to them, we have plenty of our own problems here on that score, but more about that later on.

We Americans must remember that we are not immune to history, and we must view the experiences of our neighbors as cautionary tales.

2. Many legislators and advocates confuse 'health insurance reform' with 'health care reform'. It's true enough that there is plenty of idiocy and waste in the insurance industry, but attempting to address that without examining the delivery system itself is rather like putting a band aid on a brain tumor. One of the problems shared by both the insurance and delivery systems is that the move of these industries from a mutual/nonprofit model to a public stock model was an historic economic error. This took place over the last 3 decades because the old structures were thought to be sluggish and inefficient. Unfortunately, stock companies have the imperative to maximize profits and benchmark their performance against other industries. If they don't accomplish that quarterly stock 'bump', they are in trouble with their shareholders. Is it any wonder, then, that doctors and nurses are actually getting squeezed by these systems at the same time that marketplace prices are going up?

Existing government programs only add to the market distortions created by the need to 'add value' to shareholders. The costs 'saved' from negotiations by Medicare, Medicaid and the VA don't vanish into thin air - those costs are passed on to the rest of the system. The HMOs, which were given favorable tax treatment under the Nixon administration as part of President Nixon's revenge for the failure of his originally-proposed national health insurance ideas, also do negotiated pricing. By the time that government insurance and the HMO system have taken their 'bite' out of the available revenue pie for providers, those providers then need to play 'catch up' by ratcheting up the price for those not in a position to negotiate as forcefully. Those who would contend that the free market has failed us should bear in mind that we don't really have a true one in action today, but rather something more akin to a mixed economy.

There may not be an easy way to 'remutualize' the insurance or delivery systems, but if we accept the proposition (and we should) that an all-governmental approach isn't viable based on the experiences of other countries, we should then turn our attention to the question of what can be done, if anything, to encourage private sector alternatives to the stock model of health care delivery and reimbursement. I don't have the answer to this question today, but we need to put the question itself in play, and so far it seems to be mostly missing from the national conversation.

To be Continued in December.....

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