A second opinion on U.S. health care reform

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In a recent issue in the New England Journal of Medicine, economist Jonathan Gruber praises the Patient Protection and Affordable Health Care Act (PPACA) as a "step in the right direction," even as he expresses a healthy skepticism about PPACA's capacity to control escalating health care costs, which he recognizes as "key to the long-term viability of our health care system." Gruber also argues that there is "shortage of evidence" regarding which approach will meet Americans' health care needs while controlling costs; therefore there is "no consensus" on what works [1].

Had Gruber looked beyond the U.S. borders, however, he would have found plenty of evidence. For instance, he would have found that U.S. consumption of health care as measured by critical indicators — per capita annual doctor visits, length of stay following heart attacks, or length of stay following normal childbirth – is no greater than the OECD average, and therefore cannot justify the extraordinary level of U.S. spending [2].

He would also have found that U.S. prices for medical care commodities and services are significantly higher than in other nations and constitute a key determinant of U.S. overall spending [3], and that such prices are determined by the exceptionally high administrative overhead caused by the system's fragmented, public-private financing [4] and by the comparatively limited market power of American patients vis-à-vis their counterparts in countries with national health systems where the government negotiates prices with drug and medical device companies [5]. And he might have concluded that PPACA will do predictably little to change all this.

Moreover, the international literature would have shown the author the extraordinary international consensus around nonprofit financing to cover medically necessary services [5].

But what about the dramatic expansion of coverage promised by PPACA? Is this not a step in the right direction? The problem is that insurance coverage, as desirable as it may be, is not health care, but just a means to that end. And the U.S. system is notorious for providing coverage without care. High co-pays and deductibles are significant obstacles to access. Nor does health insurance offer financial security: nearly 78 percent of personal bankruptcies in 2007 that were linked to medical debt involved persons who were insured at the onset of their illness or injury

[6]. PPACA, by allowing the sale of premiums for policies that will cover only 60 percent of health expenses [7], will do predictably little to change this state of affairs.

There is, however, an alternative proposal whose financial and policy soundness are based on decades of international experience and evidence. It would improve and expand Medicare to include all residents in the nation or in one state. That alternative may have to wait until PPACA unravels, as it predictably will [8].

President Obama argued that a model of reform as that implemented by PPACA would allow Americans to build on "what works" [9] – a decades-long experience with employer-sponsored for-profit health insurance. Maybe paradoxically, however, PPACA will unravel as employers realize that it is cheaper to pay a fine than pay for increasingly more expensive and inadequate policies, and employees enter the individual health exchanges implemented by the new law and find them so expensive that they "clamor for a nationalized health care system" [10].

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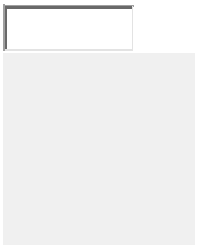

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