



## HEALTH CARE SYMPOSIUM, 2009 MAY 13, 2009, N.E.A., WASHINGTON, D.C.

### SYMPOSIUM SUMMARY: ANALYSIS, THE ECONOMIC BASICS, AND THE CORE POLICY QUESTIONS

This report summarizes the facts and arguments presented by speakers and observers at Dialogue on Diversity's recent Health Care Symposium, along with some of their conclusions, with implicit policy recommendations. We hope that the points made in our discussions of May 13th will be useful in shaping the health care legislation the Congress has set about fashioning. The ideas and analyses set out here are not necessarily those of Dialogue on Diversity as an organization or of the Symposium panelists generally, but are those of certain Symposium participants and observers who have had a hand in writing the present document.

I THE MORAL AND CIVIC CASE FOR HEALTH CARE REFORM Under an evolving public philosophy it is probably realistic to speak of the entitlement to health care as a pretty basic "right" in contemporary society – in this respect American society appears to be playing catch-up with most of the European countries. The duty in the federal government to see to it that a full and decent measure of health care is provided to the country's inhabitants rests, first, on humanitarian grounds, but also on considerations of human capital investment, which is required for dealing with the demographic bulge lying ahead over the next few decades.

The Symposium of May 13 did not deal with the questions of dental services and mental health care. These have for long been viewed as separable from the core medical care items. Dentists are thought to have attained only to a skill level inferior to that of the medical doctors. As for mental health treatment, it labors under the twin disadvantages of stigma and a suspicion that it is all a pseudoscience, designed for a range of pseudo-ailments. An enlightened view of both would see dental services as directed to keeping in working order a set of valuable hardware, the teeth, which are part and parcel of the physical apparatus, capable, if disordered, of causing notable discomfort, and propagating infections through the rest of the body. Mental sicknesses, in turn, are not voluntarily devised fancies but afflictions as painful, devastating, and otherwise real in their effects as those more traditionally dealt with by the medical professions. But if these are not soft sciences, existing by sufferance next to the hard sciences of medicine, then it is not clear how any "right" to medical treatment, or health care, might logically stop short of covering these too. In the argument below no specific reference is made to either the narrow or the large conception of "health", as in "health care".

### II ECONOMIC BASICS

A. CURRENT AND INVESTMENT CHARACTERISTICS OF HEALTH CARE EXPENSE. For both individuals and governments expenses of health care are aimed, on the one hand, at warding off or curing *present sickness*. These same expenditures, aimed initially at remedying immediate ills, along with a variety of other, genuinely long-term health care measures, are, on the other hand, designed to prevent *future sickness*, or, to state the positive side of the matter, to fit the health care consumer to be an able performer in the workplace and in domestic life throughout the future, with a full and fit set of mental and bodily faculties. In this latter class of expenditures, essentially a cluster of investment transactions of the "human capital" realm, the outlays are like those for houses, for roadbeds and bridges, shares in

enterprises, and other long term assets. It is appropriate that each of these projects – each the building of one or another species of long-term assets – be financed by borrowing. (In the case of local governments, by issuance of municipal bonds. The Federal Government may also issue bonds – under present systems of accounting these transactions are set down as a deficit in the current account budget. The grandchildren may have to pay for it, but the same grandchildren inherit a measurably fitter and more productive society that is more than worth the debt service. It is a serious logical error to complain of investment expense, with its consequent debt service, and at once to ignore the stream of returns generated through the future. As to whether and how these returns are amenable to quantitative measurement, see discussion below, Editors Note: More Health care – Where Will it End?).

B. ADVERSE SELECTION AND WHAT TO DO ABOUT IT. An Insurer will obey the incentives of the market to choose for its pool the persons of low sickness probability. If the insurer sets up another pool for persons whose probability of sickness is greater, the premium sought is correspondingly higher. Finally, for those seriously sick, if they are to be insured at all, it is for an extremely high premium. The gene lottery, the vagaries of chronic diseases, the incidence of accidents, all place one willy nilly, as consumer and patient, into one or another of these categories. The practice of prevention can influence one's placement in this classification, but not enough to reverse the outcome in the face of the above-mentioned overbearing causes. It is offensive to a sense of social justice that the unfortunate ones afflicted with a high sickness probability should be left, through this phenomenon of “adverse selection” (the not particularly illuminating term that has come to identify this cluster of effects), to suffer with their unfavorable lot. Thus there is a need to redress this disadvantage in any humane health care legislation – not only humane but as a system calculated to fit the sick to survive and fight again another day, and to preserve the society from duties of long term support or from infections and other things that public health experts worry over. *The difficulty can be overcome by a subsidy for the high-sickness-probability consumers.* Under one plan variant these consumers could go ahead and pay the high premiums and be subsidized by the government for the excess over a “normal”, or “reasonable” premium (or, in the case of the very affluent, for some portion of the excess). Alternatively, the insurance company could charge everyone the same normal, low rate, and be subsidized by the same excess (plus some kind of administrative fee). Again, the employer (more accurately, employer-or-insurance exchange) presiding over the plan for its employees/clients could pay the high insurance rates and receive the same subsidy. The choice of one or the other device might seem a matter, in the first instance, of “merely” minimizing administrative costs. A sufficiently careful view of the question will make imperative, however, very nicely articulated flows and destinations of subsidies in order to place incentives where they will drive activity levels and prices to the socially expedient levels, as laid out below in some detail.

C. THE FUTURE OF MEDICAL CARE. Over the longer run concern centers on the pressure of medical costs, incurred for the large and growing number of persons burdening the system through the inexorable progress of demographics. The provision for future expenses has been made up to now by way of a so-called trust fund. One does not, of course, store up grain, television receivers, gelato, or nightshirts for the elderly or sick, all stashed in a vast granary, to be raided when the beneficiaries reach a certain age or at length fall sick. Clearly the costs of their retirement or their sickness is to be born at the future time out of the resources, the flow of current production of the larger society, at that moment in the future. *The key present policy need* always is to ensure by previous, sufficiently provident, investment policies (investment in both human and physical capital) that production is running at sufficiently high levels at the future time to *meet the expenses of the demographic bulge and still leave enough production to support what the rest of the society (the young and able) consider to be a suitable level of consumption.* The trust fund –

which, it is often noted, may at some point run out – is simply a specification of some of the financial choreography to support the essential economic realities described. The bonds held by the fund are, in due time, sold off to the Treasury for cash, to the Federal Reserve for newly minted cash, to domestic financial entities, or to foreign buyers, again for cash. If the fund had “run out”, then the Treasury would issue new bonds, disposed of to the same clientele, or levy taxes in the requisite amount.

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ON THE USE OF TAXES TO REPLENISH TRUST FUNDS. The cure for the future woes of the entitlement programs is, quite clearly, to provide – something that has got to be done a good deal in advance – for an enhanced productive and services capacity sufficient to throw off the needed goods as required at a series of points in the future, so that the community can then pay for the elderly and unproductive and for the sick who will then burden it, all at a level satisfactory to those recipients, and yet not withdraw any significant amount of consumption from the rest, not, that is, diminishing consumption for the working population below a secularly customary level. At that future date the subventions for the weak and the sick will be paid by directing a portion of the total of current produce from the producers to the receiving parties. That is to say, by a current taxation laid on, or bonds sold to, the former – the question is how painful that will be. Raising present taxes on commercial activity – employment, enterprise, and the rest, however one state it – is not apt to enlarge the productive capacity of the commercial and productive system as that capacity will stand at a future date – *unless, of course, the funds raised by such taxation are turned immediately to investment, perhaps in a variety of carefully chosen, expeditiously designed human and physical infrastructure projects.* But absent such disposition of tax collections, heightened taxation plowed into bonds in such ways as to leave investment activity unchanged or diminished, constitutes a perverse manipulation of bookkeeping entries – a matter of distributing inadequacies that will come to plague the community at specified years in the future. It is this steady, studied course of investment that Mr. Greenspan had plentifully recommended in repeated, but sparsely regarded, statements before the Congress and in speeches to business audiences alike.

D. THE HIGH AND GROWING COSTS OF HEALTH CARE. The painfully evident facts on medical and health care expenses display swift and persisting rises in an aggregate, and in per capita amounts, rises in both cases outstripping the rates of increase in most other kinds of expense an advanced society encounters. Factors such as high prices of pharmaceuticals, heavy administrative expenses in the insurance industry, an often loosely defined disparity in “efficiency” from city to city, hospital to hospital, etc., and litigation, among many others, are widely alleged to be the chief causes of high medical expenditures. Since these items are already in the mix and thus are not factors apt to raise prices prospectively, they are not counted as elements in the rising costs, but their remedy in some cases is counted as an element causing a prospective drop in costs. In the following, some of the factors determining the increases to be expected from here on – some of which public policy can effect, others not – are set out just below.

A remarkable bulk of the popular (inclusive of legislative) discourse on the cost question seems permeated by the persuasion that an extension of medical services to the very significant part of the population now hanging on with much less than adequate care, and at once the removal of the expense disadvantage impacting persons burdened with existing medical problems (or prognoses of problems) – all can be accomplished without large additional aggregate health care expense for the society as a whole. In accord with this belief it is asserted that present per-unit costs levels are amenable to large savings measures, that the costs are currently determined in arbitrary ways, by agents and institutions actuated as often as not by malevolent intentions, that sloth, greed, and witlessness are the order of the day in the industry, that the massive investment in equipment and hospital installations can be supported without the prospect of dividends paid to shareholders, or an enhanced share value generated through a reinvestment of profits

(although no similar complaint is generally raised against outpayment of roughly equal amounts required to service the functionally equivalent debt financing employed by not-for-profit medical facilities). When all the fraud and waste are excluded, all the pockets of greed and exploitation emptied, all the voluntaristic remedies tried, the costs are pretty surely going to remain, as intractable as ever – except for the influence of those real economic forces, described below, that determine them over, respectively, long and medium and short run horizons.

FACTORS TENDING TO RAISE COSTS: 1. Innovation. Treatments are devised for disorders previously not treatable at all; the price has thus fallen from infinite to high-but-finite. Elemental price theory says that at this lowered price more will be demanded. There is thus a natural secular trend to larger and larger amounts of resources and funds directed to the health care sector of the economy. Thus, in a long-run sense, there is no “normal”, or “correct”, expense portion for the bulk of health care in either individual or social accounts. 2. The enlargement of the health care consumer base through such legislation as universal health care provision will raise the aggregate spending on health care, but also it will place some upward pressure on prices of the resources that are drawn into service in the health-care industries, in particular such scarce and specialized resources as highly qualified medical personnel, specialized hardware (say, MRI machines), etc. – these effects, which are per unit price rises, are short-run to medium-long-run in their persistence. 3. Jumps in investment costs in the same short to medium run through adoption of IT, bringing on line added buildings and other non-specialized facilities for the enlarged patient base. 4. An income effect, adding to the per capita spending on health care in response to an increase in income, which has historically exhibited a secular upward trend, one which it is plausible to suppose will continue. What is in question is whether the cluster of health care services work as a superior good, spending on which is likely to increase more than in proportion to the increase in income. It appears, intuitively, that the income elasticity of health care services is greater than one, that is to say, that a 1% rise in income is likely to generate a rise in health care spending of more than 1%. If, on the other had, as some “adequate” level of health care services is at length attained, so that no matter how affluent the population comes to be, no added health care services are required, then the elasticity is zero and the cost problem will diminish secularly as income rises. The former rather than the latter is the outcome one would bet on, at least for the foreseeable future.

FACTORS TENDING TO LOWER COSTS: 1. Adoption of IT and its interoperability. 2. Simplification of administrative procedures, *changes in the tasks of insurers away from the costly assessment of individual prospective insureds and at once away from the tasks of analyzing and enforcing the array of exclusions that would no longer be part of the insurance contract with the insured consumers.* 3. The effects of heightened prevention efforts (described below). 4. Possibly a reconfiguration of the economics of the pharmaceutical industry – this is outside our present scope, but is doubtless where much of the large economic effects will be found to lie.

*The legislation to be considered can operate to hasten the production of the human and hardware resources needed to cope with an enlarged health-care consumer base (converting some of the above medium runs into short runs). It can remove from insurance companies the job of individual assessment of prospective insured persons and otherwise cut through massive layers of bureaucracy and red tape. (It is here that the larger fat deposits in the health care system are often thought to lie. See, e.g., Prof. Krugman’s writing passim and studies cited therein.)*

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### III. CHARACTERISTICS OF A RECONFIGURED HEALTH CARE SYSTEM

A. UTILITY OF A “PUBLIC PLAN” A public plan could be set in place as the exclusive entity purveying health care (aside from the residual private high-end providers described in section I. below). They

would be available as an industry standard, operating without certain incentives that impinge on private sector insurers to lead them in objectionable directions. The dangers would be that the public plan would be likely to stifle innovation unless safeguards were carefully set up by statute and managed by an alert HHS. If it were the sole plan this especially would be a point of caution. If it is one among many, the cause of innovation would be likely to flourish from the multiplicity of players.

B. . . . OR PRIVATE PLANS. Private plans would best be set up to deal with insured persons without regard to their probabilities of falling sick. The insurance companies would be compensated; they would receive the necessary subsidies for bearing this (very substantial) cost. There would still remain an incentive for them to practice forms of adverse selection around the edges, more or less surreptitiously, so that a properly designed system would set up “watchdog” commissions to monitor any excessively clever tactics.

In general, private plans would atrophy if the public version is genuinely more efficient and agreeable to deal with and no more (perhaps less, pace the even playing field consideration) costly. Again, the public plan would atrophy if the private-sector plans thrive and produce effective competitive action yielding cost savings and innovation. Or, indeed, both could indefinitely co-exist (cf. USPS and UPS, FEDEX)

C. PORTABILITY OF HEALTH COVERAGE. In any fully articulated statutory schema, the field of “private plans” would have to include not only employer plans but similarly constituted plans set up with much the same functions in other than workplace settings. Consumers would in fact have the choice of sticking with an employer plan or associating themselves with one of these other plans. Upon changing employers or for other reasons shifting one’s “business” to another, competing plan, the consumer would wish to carry with him some semblance of continuity of the insurance coverage. To be sure, the principal reason for desiring portability has heretofore been to escape pre-existing-conditions rules in a new employer’s or other new plan -- by hypothesis that particular fact would no longer have impelling force since prospective insureds would be taken on without consideration of existing health conditions. It would have to be specified whether the continuity would be required by way of the same insurer and insurance policy or through a roughly equivalent policy with an insurer and policy specified by the new employer. In the former case the employer or other plan administrator would have an almost purely ministerial function, dealing, like a travel agent, with a multiplicity of carriers. In this model one is brought back to the proposal worked out by Dr. Stuart Butler of the Heritage Foundation, a system in which the key role is played by an entity called the “insurance exchange”, which might be an employer or any other organization or office offering a shopful of varied insurance companies and policies.

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## EDITOR’S NOTE

AN OVERVIEW OF SYSTEMS. THE FUTURE OF COSTS The sections following, analyzing the economics of a possible health care system, in which private medical insurance plans and private-sector companies would operate under “ground-rules” set by the government, and in the presence, in a sort of “cohabitation”, of a public health insurance plan, propose to sketch the main features of the array of incentives that will necessarily be in play in any actual scheme of health care insurance coverage. It is the intent of these sections to illustrate the ways in which the alternative rules and legal arrangements will skew these incentives, with a suggested system of rules, and their implicated incentives, that might achieve much of the cluster of purposes to which any health care plan will be directed.

This discussion concludes that the essential purposes cannot be realized without substantial costs, at least in the short run, and that with appropriate direction, the health care system may evolve, over a somewhat longer run, to a system with lower, more tolerable cost levels. It is, in any event, not clear how one can talk of a “right” to health care without prescribing the withdrawal of social resources in requisite, perhaps surprisingly large, volume from the totality of GDP, partly by way of taxes (or borrowing), partly by way of induced private expenditures. The vaunted Canadian or European-style medical care systems, with free care for all comers, while being generally praised for their virtues, are at the same time typically arraigned for their long waits, the scarcities of specialists, and even exclusions of patients from costly or scarce treatments (opponents of a “socialized” system of health care point to such horror stories as the turning away of the elderly from urgent dialysis treatments and the like). These drawbacks in the structure of an otherwise attractive system are the pretty obvious result of a meagerly funded service apparatus. Probably this is unacceptable in the U.S. setting. Resources of skilled personnel and amply outfitted clinics are costly but necessary, and sufficient price (salary) incentives must be provided to draw able persons into these professions in numbers sufficient to handle the newly arriving patients from the previously marginalized reaches of society. Nor can any U.S. system rely, as other countries, Canada among them, continue to do, on the provision of cheap pharmaceuticals, since the U.S., through a régime of patents-and-high-prices or, alternatively, through substantial government R&D subsidies, has got to play its starring role as the engine of technological advance, bearing the massive costs of innovation in this now dominant branch of the medical services picture.

MORE HEALTH CARE – WHERE WILL IT END? A pertinent problem, at this juncture, is that of specifying the mechanism by which, at some point, the competing uses of the society’s resources will necessarily call a halt to further expansion of expenditures on health care. As a common-sense or legal proposition some standard of “reasonableness” might impart a due measure to the expansion of health care activity, but as an economic question the difficulty persists: does the consumer at the margin experience the increment of deprivation of other goods as he expands his requisitioning of health care? One solution lies in the proliferation, suggested in this paper, of insurance policies providing more or less ample, more or less extensive coverage, and – what is the key to the effect – at *different (higher or lower) levels of the low-risk-class premium*. In this way consumers would compare the increment of non-health care goods they might enjoy in preference to any specified incremental elaboration of their basic health-care package. Proviso, that the package would, as noted, necessarily cover some basic level of preventive services and any form of medical expense that, if not picked up by insurance, would be catastrophic (bankrupting) – terms that would have to be defined in a reasonable way. The low-level package might provide, for example, for interviews with the nurse practitioner (well trained to be sharp-eyed for the grave masquerading behind the trivial in symptoms) for the apparently less serious complaints (sniffles, scraped knee, indigestion), for tests limited to standard issue, or limited in number to only non-redundant tests, etc. Again, a braking effect would operate if, for the affluent, there were some deductible amount or co-pay (devices that are contemplated under the systems suggested). A less obvious but at root deeply significant brake lies as well is the fact that consumers themselves do incur costs (costs which, like many, are ever so real in spite of their not showing up as recorded money transactions) in seeking and receiving health care – that of time, transport, and irksomeness, as noted elsewhere in this paper. At a certain point in an imagined health care expansion, one would prefer the ball game, a picnic, or even a remunerative trip to the office as the alternative to yet another visit to the medical clinic, with its white-robed ministrants and the sharp-pointed tools of their trade.

In the larger view of the health care industry and its future, American society, through a heavy investment in health care (demanding outlays probably much greater than it has heretofore contemplated), will experience a future stream of substantially higher productivity through the enhancement of its human capital resource – and quite apart from the humanitarian considerations that might independently recommend a much improved health care régime. The key is to conceive of health care reform as an investment proposal, and it is the investment returns, probably quite large, that must be carefully gauged, both as to quantity and quality, as U.S. society and its legislators labor to fashion the details of – what is essentially involved – the health investment transaction. It is

sometimes urged that since these returns are of a more or less speculative character they are to be set at zero in evaluating any present outlays for shoring up the medical services industry. One response is that zero is an arbitrarily chosen number and that any other value, high, medium, or low, is only equally arbitrary. But zero, among all other possible estimates of future return, is not necessarily of equal *probability*. It is the task, however difficult or of uncertain fruitfulness, to form the best estimate practicable – intuitively, a rate of return far above zero!

#### LEVEL PLAYING FIELDS. IMPERFECT COMPETITION

The much vaunted doctrine of the Level Playing Field has taken on a certain prominence in the public discourse foreseeing a fateful encounter of public and private health care plans. The notion of the level playing field is apposite in the design of games. One imagines a race for which the swift horse is loaded under a heavy jockey, while the clumsy, lumbering nag is topped with a light jockey, the purpose being to even the chances of the contesting parties and thus make a good race of it. Under the very much contrary logic of a working commercial system, on the other hand (the class of affairs that are characteristically analyzed through the conceptions of economic theory), the fundamental purpose of the market is to ferret out the relative defects and disadvantages of each actor in order precisely to describe an architecture of unevenness. Just as the goal of a level playing field is a generally inapposite notion in any discussion of international trade, it is clearly inapposite in any reasoned consideration of health coverage plans -- however constituted and by whomever sponsored. The object must instead be to permit the intrinsic faculties and virtues of each, along with the imperfections or inefficiencies intrinsic to each, to be displayed – and at that as rapidly as possible – and to permit those plans that are either superior or inferior to others, either to advance in size and influence, or, for the latter class respectively, to fade. The meaning of this is not as obvious as it might seem on the surface. What elements of the public plan, for example, are intrinsic to it, so that they are a reasonable and useful part of the competitive encounter with other, private sector plans? A subvention for the public plan from the Treasury so that the plan might offer services paid for otherwise than by premium revenues would be *extrinsic* to its operations as a medical coverage plan and would thus not be a correct item in its accounting and, specifically, not an admissible device for lowering its premium levels vis-à-vis its private-sector rivals. On the other hand, the broad geographic scope for the public plan, any possible differences in its personnel practices, its wage structure, its supply arrangements with vendors, a streamlining of its administrative apparatus – all these would be very much intrinsic to its operations and would be appropriate devices for lowering its premiums or, alternatively, enhancing its services to consumers. A somewhat more elusive point is the question of how to treat capital investment by the public organization to be set up to conduct the government plan – the acquisition, for example, of office space and equipment, the use of data facilities maintained by offices in the government other than the newly constituted insurance plan. If these investment items are to be paid for by issuance of bonds, would the government plan, in handling the subsequent debt service, be permitted to piggy-back on the government's good credit rating? These questions once settled, and the government plan's premium/service offerings presented to a waiting public, the private plans would have to keep up if they proposed to remain viable. If the opposite were the case, so that private plans were regularly coming in with lower premiums than the public version, then the public plan would in time become vestigial. A possible problem at this point would lie in the effects of state laws, or indeed other federal regulations, that would inhibit private insurers from operation over specified geographical boundaries, or with certain personnel practices, etc., in such a way as to interfere with the requisite competitive mechanism. Such rules would have to be overcome if efficient competition on the above principles is to be achieved (probably by appropriate provisions in the legislation establishing the reformed system).

Another facet of this question lies in the potential effects of imperfect competition, that is, oligopoly, on the private insurer side. It appears that under present conditions, certain insurers account for very large proportions of the insurance coverage in force in their localities, so that some form of tacit collusion might be operating to keep premiums high. Against this effect, one can, first, have recourse to anti-trust enforcement under existing

rules; but also such artificial price elevation would be undercut by the effect of the public plan alternative in all localities, it being assumed that the public plan itself would be immune from any form of collusion.

OLIGOPSONY AND PRICE DETERMINATION: ONCE AND FUTURE Another point playing a large role in public discussion is the imputation of oligopsony powers to large purchasing entities, typically insurance companies and indeed the government itself – colloquially stated, that large entities can utilize the power inhering in their size to exact more favorable deals from vendors. The evil is not that the vendors so squeezed would be making less money; it is that there would be fewer of them and the “natural” price would have been pushed much higher so that even after the oligopsonistic squeeze there would be the normal and acceptable return to effort for the vendors, that is, the hospitals and doctors and others on the health care supply side. The harm instead is that the quantity of medical services would be artificially diminished for no discernible social good. Whether such powers in fact exist to any substantial degree, or whether instead the differences in price derive from some sort of administrative efficiencies in transactions is not clear. (It is often argued, for example, that the risks are more readily ascertained with large pools of insured persons, while for small employer-based plans and with individual plans the risk determination is more costly per insured person; at the same time, in the transactions between large employers and large insurance companies one may indeed be confronted with some measure of bilateral monopoly, which is a scheme traditionally difficult to dope out.) The mechanisms for a health care system outlined here would largely prescind from this situation by requiring that a single price be charged by vendors to all comers. At the same time some of the administrative cost differences arising from the need to assess sickness-proneness would be removed. Administrative cost differences that remain, as noted elsewhere, would come into play in the determination of insurance premiums, not provider/supplier prices.

COVERAGE FOR CATASTROPHIC INCIDENTS: The insurance policies offered by private and the public plan must, like ordinary umbrella policies, cover medical expenses as high as they may go, without a cap, so that one does not again throw the persons affected with catastrophic losses back onto the responsibility of others – the providers in the event of bankruptcy, the taxpayers in the other case, where the government is invoked as the residual picker-up of pieces. Another key feature of the policies must be that they do not take into account sickness proneness for setting premiums. But most decidedly the medical conditions of persons, *independently of their insurance status*, must be taken into account in the larger system, precisely so that the disease likelihood of individuals may be exhaustively assessed and needed preventive measures accurately designed. This may be done most appropriately, one would guess, by medical providers, not by insurers. The full disclosure of the facts of medical histories at *some locus* in the global system is of key importance, but in the insurance function, as revised, not.

## THE TRICKY METHODOLOGY OF SUBSIDIES

Could a system properly exist in which insured were carefully screened by insurers and placed in premium classes, with subsidies arranged to insurer for each class? There would be the temptation, otherwise mentioned, for insurers in these circumstances to insinuate the high quality insureds into lower quality risk classes (with larger subsidies). Here the insurers are expending large sums for the evaluation process, and much effort in gaming the system – results to be averted on both counts.

Discretion must lie with insurance plans as to payment levels to Providers for specific services (the locus, as elsewhere noted, for disapproval of novel procedures), but any such disapproving decisions must be appealable by insureds (the residual obligors) or providers, (who would have to collect), and response upon appeals must be swift, reasonable, and perhaps with a bias toward innovation, by an independent authority.

A clear necessity at the outset is a common scheme of accounting among insurers, among these the government plan. All this to ensure no leakage as to the public plan, from sources extrinsic to the business operations of the insurance function. (doubtless ambiguous around the edges, a matter of continuing attention when new devices are contrived to render leakages to appear intrinsic to the insurance operations. This implicates the vexed question of the level playing fields. If a leakage into the public plan occurs, then this amount must be paid by the fisc to the private plans pro rata – that in order to maintain the viability of the plans properly gauged.

PRICING PRESTIDIGITATION: WHY AND HOW IT IS TO BE SHUNNED. The prices charged by providers for services should be a single price, given to the plans without discrimination, and to individuals not insured, except for luxury services sought apart from any plans. (Subject, however, to differentiation by service-enhancement class, as noted below, but only upon evidence of real distinction in quality of service).

It is an exacting, but centrally important, task to estimate insurance company outpayments as if insureds (insured persons, consumers, patients) were of the prime (that is: minimum) risk class. Then the needed subsidy is equal to the actual payments rendered by the insurer – minus the premium revenues, which in turn are the prime risk class premium times the total number of insured. The insurers, absent oversight and prospective sanctions, would tend to elevate the prime premium, this by the expedient of including riskier insured persons, with the intent of raising the premium. But this tactic on the part of the insurers is only so likely since it would lower their subsidy amount, and since it would drive persons actually in the prime risks class away from the violating insurer to a rival company, one that figured the low-risk premium properly. If, however, the insurance company posting a higher prime risk class premium does so by reason of its providing a superior service, then the premium differential is sustainable in the face of the acts of rival companies. *The schema being outlined thus does not dictate any particular premium level, but in a competitive market the price for a certain health care package will tend to be the same over the range of competitive suppliers, with differences on account of ancillary features of the arrangement, speed of processing, for example.*

The very difficult question that lies at this end of this path of reasoning is how to set the prime class premium. And, once it is set, what is to prevent the insurers from paying recklessly high fees for services of providers since the government, under the proposal, would subsidize the insurance in the amount of the excess of outpayments over the prime class premium — and not under a price schedule for specified kinds of services. (Indeed, one of the prime desiderata in any health care system is to steer clear of price schedules, any imposed by the government, maintained by insurers, or otherwise in force!) The solution to the difficulty lies in the rule previously mentioned, that providers must charge the same fee to all insurers, all patients, at all times. *The insurer desires the lowest prime class premium, since this is what the consumers pay, and is therefore the mechanism for gaining competitive advantage (more elegantly put, for being viable in a competitive market at all by charging the single uniform competitive price) among insurance companies.* They have a compelling interest, therefore, in exacting from providers lower rather than higher prices. There is still the problem of the pricing of novel services, those, arguably, that occur mainly (but not solely!) in the less than prime risk classes. Since these would have to be taken into account continually and the prime risk amount adjusted continuously, their absence at an imagined initial point, would be irrelevant. The government throughout would observe, audit, and act on the prime class premium level, but would not set it. Or determine when and how often it might be adjusted.

Providers, in setting their own prices, will at all events stand under the gun of a competitive market, and would be bound (both by rule and by the necessary mechanisms of a competitive régime) to charge the same price for all comers – as noted, a core postulate of the competitive solution. It does not matter initially whether different providers charge different prices so long as they do not discriminate among consumers/customers, but by hypothesis this state of affairs would not persist, since competitive pressures would produce a single uniform price across providers.

*The government, or one or more independent bodies contracted with by the government, would conduct continuing audits to ensure that the rules prescribed were being observed and to ascertain the amounts of payments (the outpayments, that is to say, made by insurers), that is to say in turn, the subsidies to be supplied by the government.*

FURTHER SUBSIDIES: THOSE FOR THE LOW-INCOME STRATA Still another question -- and perhaps the one dwarfing all the others, although not requiring equally intricate mechanisms for its solution -- arises once the prime class premium is set, a premium which all would pay. For the affluent this is no problem; for the very poor, or more precisely stated, for those whose incomes are below certain specified levels, this premium will be more than what can be reasonably afforded. This implicates the larger question of progressivity in income taxation, the use of such devices as the negative income tax, or other means for affecting the income accessible to the persons initially without funds equal to the sum of expenses for housing plus health insurance plus food, clothing, and other necessities, plus a socially obligatory quantum of "amenities". One solution, not a preferred one, is that the government would transfer funding, through some form of vouchers, to those at various inadequate-income levels. This is not the best solution since it adds to the economic potentiality of the poor by a very specific aid confined to a certain type of consumption, while a general empowering through such means as the negative income tax, would permit the poor recipient to allocate the enhanced income as desired over all forms of consumption -- the classic recipe of welfare economics. And indeed the type of health care system here outlined would permit consumers to elect somewhat more or less costly and elaborate health service packages. This scheme, which is clearly a necessary component in some form is clearly redistributive in effect, a salutary dose of what one might presume to call Chicago communism.

CONSUMERS LEFT BEHIND — WHAT BECOMES OF THEM? Consumers found to have remained -- by intention or by inadvertence -- outside the system would be involuntarily enrolled in the public plan, to be billed for the actual costs of the treatment up to the attainment, when cumulated with previous service costs (those incurred within the year then ending), to the amount of the premium for the year ending with the attainment of the cumulated amount to the amount of the yearly premium. The question of a universal mandate, in the customary phrase, rather than some other scheme of extending coverage over a population, deals with relatively paltry epiphenomena in the face of the large and powerful economic forces in question, and the situation, as suggested here, could be dealt with by a fairly painless administrative transaction. As noted earlier, consumers wishing to purchase health care services outside the system may simply pay the service fees to providers without involvement of the public plan. See paragraph H on their position and its rationale.

ECONOMICS OF PREVENTION: A WORKABLE SCHEME OF INCENTIVES. Still another factor in the pricing arrangements may well be the question of incentives for preventive practices among consumers -- and providers for that matter. For several reasons it is unlikely that, under the schema being outlined here, consumers could be effectively motivated by acts of the insurer by way of discounted premiums on their policies. First, any prevention-induced improvement in health would be reflected in lesser payments out by the insurer for medical services, exactly matched by a reduction in the aggregate payments received from the government on the adverse selection account, and, second, the insurer in any event would be less than certain to enjoy the benefit of the health improvement since consumers could change insurers easily -- long before the range of preventive effects had run its course. Thus any premium discount, even if otherwise rational, would be measured by solely the preventive effect produced in the current year or other term of the insurance policy. Instead the prevention incentive would have to be effected by the government's paying the consumer. In its amount such a payment would be measured by the government's saving on payments to the insurers, which is equal to the drop-off in the amount of outpayments of the insurer (see the adverse selection logic, laid out above). This lessening of outpayments by the insurance companies corresponds to the lessening of required medical services permitted by reason of the preventive practice by consumers. The government has savings in an aggregate amount equal to the amount of prevention bonuses, or rebates, to be paid to the prevention practicing consumers. The metric by which an individual consumer's prevention efforts might be gauged would be computed by reference to a record

of tests or check-ups. (Lifestyle practices do not lend themselves to a practicable system of monitoring, but it may be a fair guess that persons diligent in getting checkups are also likely to observe the common “lifestyle” injunctions promulgated by the medical and public health community, so that the aggregate preventive effect will be consistently picked up in the check-up measure alone). The other measures can be tabulated and the bonuses declared to each consumer out of the aggregate pot pro rata. In a larger view, the effects of the genetic lottery and the chance events of accidents and contagion are socialized, that is to say, paid for out of the funds collected by the fisc out of general tax revenues – which is to say, in turn, from the population generally. But on top of this, under the procedure sketched here, the achievements of preventive practice are taken out of the socialized burden and remitted to those particular persons in the society whose preventive efforts have mitigated the social aggregate effects of sickness.

[Conclusion of Editor’s Note]

D. PHARMACEUTICAL INDUSTRY. This large industry, the uniquely massive and crucial player in the health care universe, might well be the subject of separate legislation. Desiderata: low price levels to consumers; ample funding for market-indicated research and development targets, but inclusive as well of those targets where humanitarian interests dictate action for which incentives are not afforded by the price patterns yielded by the private market players; ample rewards for effective research and development – presumably through large public subsidies (the far from unique case of public goods produced with the savings from falling prices of the commodity yielded -- here prescription drugs); a menu of research priorities, including diseases in other parts of the globe, ailments affecting non-affluent sectors of domestic and other developed country populations, and perhaps other research propagated through purely private price transactions. The pharmaceutical industry was not treated in detail in the Symposium and is not extensively analyzed here. Its economic logic is, of course, while not unique in the character of its elements, more or less a model of its own in the particular magnitude and complication of these elements. This model must be kept relentlessly in mind in any attempt to regulate, let alone restructure, the industry.

E THE COSTS, DIRECT AND INDIRECT, OF LITIGATION. Still another source of needless high costs in the health care system is often argued to lie in the system of tort law, compounded by an attendant litigiousness in the temper of the society. Inspired by the exploits of crusading lawyers at the time of the Watergate scandals, a generation of the best and brightest have flocked into the legal professions, with the effect, inter alia, of pushing the envelope of tort liability as to medical practice, pharmaceutical development, and other, related fields. This phenomenon may have costly effects in two directions, first by enlarging the amount of insurers’ legal defense costs and payout costs when defenses are less than successful; second, through higher treatment costs run up by reason of allegedly excessive tests and other redundant or only remotely pertinent medical procedures, those undertaken in order, prospectively, to rebut any imputations of insufficient care, not to mention the thought that some practitioners, out of annoyance with the larger picture, have cut back practice or left these professions to raise cabbages in the country. While some of these effects doubtless do operate, not necessarily to the real benefit of the larger state of health care, the remedy may not lie simply in placing roadblocks in the way of the legal remedies themselves, or in denying that the threat of tort liability does operate to inhibit reckless industrial or medical practice conduct. It is somewhat speculative to attach numbers to any of these effects. Intuitively, one would guess that these effects do not account for any appreciable bulk in the increases in health care prices. (The proliferation of testing, for example, may be explained to a significant extent by the entirely rational preference of patients for use of all existing tests for determining whether cancer or other serious medical problems are present.) While review of this

question lies outside the scope of these comments, it should be noted that the present structure of what one might call medical error repair renders the chances of the patient's being made whole after suffering the harms of medical error – money costs of impaired working capacity or continuing medical treatments, or the personal pain or the lingering disability that degrades domestic or social existence – a capricious proposition. Claims for real harms may be sidetracked by procedural deficiencies, by an inability to muster funding for the costly tasks of proving the case to back up the claim, and the force of such defenses as that the harm occurred in spite of due care on the part of the medical practitioners. All of which means that the attainment of redress by persons suffering harms in medical procedures is a matter, from the injured patient's point of view, of chance, in which a few hit jackpots, and large numbers of equally disadvantaged are left to sulk, in considerable discomfort, with their harms.

In a global view of this question, the enterprise of health care/medical treatment is one in which errors (for purposes of the present discussion this includes errors by carelessness, but also errors of machines, errors of meticulously careful operatives, indeed acts of god and the public enemy, and so on -- any event that produces unusual harms) may and do occur, and, since the frail, delicate human body is the subject of the sometimes mistaken treatments, these errors can impose loss and anguish of the most grave kind, with damages ranging from minor disabilities to severe pain to death. The incidence of these harms over individual patients is random, so that some form of social insurance, in which the cost of errors in the aggregate is borne by the entire community of health care users, is implied. This should probably take the form of first party insurance afforded to all consumers (who would be deemed parties to a social insurance arrangement), with payouts to be made upon an administrative determination of harm. Fault of the practitioners (the main principle of the patient's claim for relief under the traditional legal framework) clearly is of no import to the harmed consumer, and one would not buy insurance against these dangers if it had made its indemnities depend on the character of the causing acts or the mental state of their perpetrators. That is not to say that in such a system there would be no blowback against careless practitioners or ill-administered medical institutions, since private insurance companies underwriting the consumers' coverage would themselves be very much interested in the causing acts and the mental state of the perpetrators, and would gauge the premiums to be charged by these measures of error causation – since the practitioners and the medical institutions would be the sponsors of the insurance and the payers of the premia. It would not be necessary for the practitioners or employing institutions to pay the entire premiums themselves (these would be large): the incentives for care and competence would operate in the right direction even if the government were to bear, say, half or some other portion of the premiums. Again, from the point of view of patients, claims would be paid very much after the manner of modern worker's compensation systems, with no question of fault, but solely the fact of harm in the course of or otherwise deriving from a medical procedure. There is no reason, however, why any such insurance reform, which would be a major undertaking, should be entangled in the already convoluted debates over the limited health care questions now in play.

F. CULTURE COMPETENCE This topic, clearly one of high-priority, stands front and center in the thought of Latino and other ethnic communities. Any health reform measures should undertake reasonable funding for multi-lingual prevention/treatment facilities, recruitment of linguistically/culturally specialized ancillary health care staff (short run) and training of physicians and high-skilled staff of ling./cult. specialized qualifications (over a medium long run). *The offering of health care initiatives at the prevention stage, the treatment itself, and the follow-up period in a way congenial to the consumer/patient is a prime mechanism by which the aching disparities in care between the minority and mainstream population classes are to be abated.*

This question formally resembles the problems of the geographical isolation of rural or desert populations, or of persons in the urban wildernesses of inner cities – all locales where medical practitioners and first class facilities are not apt to locate, and where the sociology of health care provision may turn out to be its own science. Again, the problem can be ameliorated by such devices as subsidizing medical schooling in return for an undertaking to practice for a short term in these less “desirable” places, but any serious, long term remedy is to be found, as usual, in establishing a systematic supplement to income for persons working in these locales – probably through a special legislative project, apart from the general system of health care provision. In the longer run, the solution will probably lie, for the greater part, in development, fostered in part by government policies (surely those governing early childhood education), to bring to the now deteriorating neighborhoods higher levels of income, a reconstructed architecture and a texture of urban amenities, and the culture of affluence; and as to the geographically isolated, such enhancements of communication, through broadband internet links, perhaps telemedicine, and other devices, as may bring upper east side expertise – and amenities – to the parched death valley and the dismal hollows of the Appalachians.

G. THE GOAL OF CONSUMER CHOICE Savvy, utility-maximizing consumers afford a device for sharpening the edge of competition (among both the insurance, medical-provision, and prevention-counseling industries). A strong degree of competition would exist in any event under a standard equal-pay-per-patient or -service unit since providers would seek to maximize results, patients, service units, or other metrics. The role of competing plans, governmental and private-sector, in enlivening the competitive “game” is a central one.

This question is bound up with the goal of averting “moral hazard”. Impart a private, individualized “interest” to health care consumers, so calculated as to prod the consumer to marshal health care resources for the optimum result given his own budget constraint — which, by hypothesis, is very lenient in a world of insured health dangers, and of plentiful subsidies to boot. The dangers of the Moral Hazard are of course attenuated in this setting by the fact that the consumers in the stressful situation of medical choice are apt simply to follow the doctor’s direction. A co-pay feature, perhaps legislatively tolerable for more affluent patients, would combat the influence of moral hazard, incentivizing the patient in the proper direction, but with only an attenuated impulse. Medical services, moreover, are not costless under the system described since the costs to consumers that one always ignores, time, travel, discomfort, all are very real and operate to “ration” requests for medical care. This, reinforced by any payments for preventive practices (as suggested above), is likely at least to dull the edge of the moral hazard.

H. INNOVATION IN TECHNOLOGY AND ADMINISTRATIVE PRACTICE. While innovation is key, as noted above, to an effective pharmaceutical industry, it has an obvious role as well in improving and enlarging the broadest ambit of effective medical treatments. Administrative innovation would include new tasks for more refined IT applications; and such IT products as “telemedicine”. It is necessary to permit innovation by relaxing an absolute standardization of permitted medical/prevention procedures (which might be enforced in either public or private plans) so as to allow widespread experimentation. There is a need to design mechanisms for allowing variability and experiment while at once discouraging frivolous or reckless medical practices – a continuing balancing act, with some *fast, knowledgeable, and fair appeal facility established*. Innovation could, indeed, be an avenue for economically incentivized competition among private-sector insurers, hospitals, medical institutes, and other health-related entities even under a plan with large scale governmentally subsidized care. [See recent WSJ Op-Ed of Lechliter, Eli Lilly CEO, on the essential importance of innovation, as qualitative medical

progress is traced from 1909 to 2009 – without endorsement of his position on economic structure of the Pharm. Industry]

I. PRIVATE, LUXURY CARE Some attention should be turned to the possibility of private care beyond that afforded under the official plans affected by governmental subsidies. Affluent persons may wish to obtain care with luxury features, inclusive of “first-on-the-block” use of novel hardware, gene treatments, experimental surgical procedures, perhaps use of promising but unproven drugs, and other devices and regimens not yet become part of the standard pharmacopeia that is employed (on either the standardized or experimental basis) for patients under the ordinary plans. This would be an additional source of innovating development, alongside the experimentation contemplated under point H. above. One would have to guard against this activity’s becoming so widespread as to drain needed medical personnel away from service under the ordinary plans (this would be a short-run phenomenon since the remedy would simply be to heighten the rate of training of physicians and other specialized personnel). Fees for services described in Point I. should not be tax-deductible.

J. “SHOP” BILL AND OTHER CONSIDERATIONS FOR SMALL BUSINESS ENTERPRISES. This proposed legislation would set up consortia of small businesses, regional or national, for the purpose of creating pools of employee insureds over which the capricious incidence of sickness would not disturb the premium level, and which would at the same time reduce certain administrative costs – thus to render the insurance plans viable arrangements for employers. The employer’s choice to offer a plan would bring a federal subsidy in addition – sufficient, it is hoped, to clinch the deal. This schema would need to be coordinated with provisions in the comprehensive health care/health insurance legislation in train in the Congress this year.

K. PREVENTIVE PRACTICE. (See also the earlier discussion of the economics of prevention incentives, Editor’s Note, above). Until evidence-based initiatives against specific preventive activities are launched, the broadest array of preventive practices and measures and facilities should be encouraged, that is to say, paid for under the plan. It doubtless ought to be made part of the growing ethos of health care in America that persons should visit their main physician at specified intervals, say, once a year after age 50, and at appropriate age points to receive screening tests for a variety of maladies. Persons should contribute information to an electronically maintained general health information repository. Privacy and personal liberty considerations are implicated in this, and for that reason any form of coercive action should be made part of the system only very sparingly (in spite of the evident fact that there is a public interest in the health of members of the society). Health information should be excluded from use in various connections (the plan would avoid from the beginning, of course, its use for classifying persons for premium enhancements). All available information, however, should clearly be used for prescribing preventive treatments, further screenings, diet restrictions, and other matters, and for that reason data would necessarily be made accessible for use by appropriate (sharply limited in number) medical professionals. Through specialized efforts, perhaps with the aid of the flock of existing NGOs, prevention instruction must be carried to the marginalized members of the society, among these the poor, the isolated rural, the ethnic minorities.

L. HEALTH INFORMATION. Essential facts on prevention, diseases, and medical providers should be made readily available to consumers of health care services, the internet having made swift strides toward accomplishing this for the literate and affluent who have access to the internet and the savvy to puzzle out the medical information offered. A broad diffusion of such information is a clear requisite for conferring on consumers any meaningful choice among health plans, and between alternative

medical treatments themselves. Its utility presumes that there will be enough variety in the protocol of the health care encounter to invite choice. See the discussion above under Point G.

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**M. MIGRANT HEALTH, THE DOCUMENTED AND THE UNDOCUMENTED.** Health of domestic migrant workers is a science of its own, and some provision should be made for bringing their health care up to par vis-a-vis other health care facilities. The health of out-of-country migrants, especially the “undocumented”, on the other hand, is a problem fraught with the weight of a large body of (arguably outmoded) immigration law, and the subject of intense sentiments for and against the presence of the undocumented and their treatment under any revised immigration law. Several of the Symposium panelists spoke in favor of extending health care benefits to the undocumented just as to other “residents” of the country. To the extent that there is a public health aspect to the question, these persons should be caught up in the health care system just as everyone else. For humanitarian reasons as well, some provision for health care, especially for children, seems imperative. The question did not occupy a principal place in the discussion at the Symposium.

If the political practicalities of the migrant health question are brought into consideration, those heated sentiments that would render acutely controversial any provision for the undocumented immigrants – who number in the millions, constituting a very substantial proportion (sometimes estimated to be roughly a fifth) of the host of uninsured – the expedient course may well be to omit this class of persons from provisions of the health care bill. Against this solution, however, is the somewhat sobering thought that, in the eventuality of a deteriorated public health condition, dangerous to the point of precipitating an epidemic – a not infrequently occurring situation – the threat would be a great deal more likely to ignite into a full blown siege of the disease if millions of persons stand, largely invisible, outside the effective reach of medical services – and indeed outside the ambit of administrative access and observation that would facilitate their being rapidly brought under the purview of preventive measures launched against the threatening epidemic.

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## MISSION STATEMENT

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