

The Renewable Deal

Plank 6: Make the national health care system of the United States as cost-effective as that of twelve other industrialized nations.

Part 1: National Health Care System

Plank Six (1): Institute a single-payer national health care system with certain rationing provisions based on the probability of long-term benefit versus cost. If an individual wants to pay for treatment that the national health care system will not, that's their prerogative. (The current Medicare system already has rationing - there are a large number of procedures it won't pay for, given the patient's age and prognosis, e.g., heart transplants for octogenarians with arterosclerosis.)

--By Richard Lance Christie--

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Author's note: This is a preliminary draft and a work in progress. ([Further explanation.](#))

Discussion: In *Critical Condition* (Doubleday, 2004) Donald L. Barlett and James B. Steele present an exhaustive critique of the current U.S. healthcare anarchy, then propose a detailed solution to establishing a national healthcare policy and financing system.

Their critique can be summarized that Mathematica Policy Research under contract to the State of Maine in 2002 found that Medicare overhead in that state averaged 2 percent a year, while administrative overhead of private insurers in Maine ranged from 12-30+ percent a year of the healthcare dollar spent. They observe that Medicare enjoys economies of scale and standardized universal coverage terms, while private insurance is "...built on bewilderingly complex layers of plans and providers that require a costly bureaucracy to administer, much of which is geared toward denying claims."

Their structural proposal is to establish a "U.S. Council on Health Care" modeled on the Federal Reserve System. The Federal Reserve is a quasi-governmental organization which oversees our nation's money and banking policies. Its trustees serve staggered 14-year terms to which they are appointed by the President with the advice and consent of the Senate. Barlett and Steele propose that this Council establish and administer a national single-payer, universal coverage health care system funded by a gross-receipts tax on businesses and a flat tax on individual income from all sources. They project that this health care financing system would cost business and individual taxpayers less than the current healthcare financing arrangement. Their remedy has the following policy features:

1. guarantee that all Americans receive a defined level of basic care
2. Establish flexible co-payments, with a sliding scale of co-pays based on individual income and on the nature of healthcare system usage by the patient, including a credit against co-pay which accrues for people not using health care services. Use of preventative and chronic disease management services would be encouraged through lower or no co-payments.
3. Pay all costs for catastrophic illness: no copays or deductibles. My recommendation to Congress regarding long-term care coverage under Medicare is to establish a deductible for long-term care equal to 7 percent of gross taxable income, payable once for each episode of admission to long-term residential health care.
4. Freedom of choice of doctors and hospitals restored - the national healthcare system will pay for services from any provider so patients would not be confined to HMO staff physicians or "preferred providers" under contract to a health insurer.
5. reallocate health care spending to prevention
6. provide accurate drug information to consumers to counter drug advertising biases
7. concentrate health care spending on areas that prove cost-effective from evaluation of national health care cost and outcome data analysis
8. control health care costs by getting to the root of irrational disparities in the existing system, e.g., 48% higher Medicare expenditures on seniors in Mississippi than South Dakota after adjustment for cost of living
9. stop unrealistically low reimbursement rates to physicians and hospitals
10. stop overdiagnosis and overtreatment by identifying the most cost-effective treatments through research on health care outcomes
11. establish a single information technology system to reduce medical errors
12. allow supplementation of the government insurance with private health care insurance as the customer may please
13. Decriminalize health care fraud, making it a civil offense with provisions for both financial recovery and penalty assessment with ability to seize any assets by the offender to satisfy the judgment.

Plank Six (2): Institute a system equivalent to that already used in the EEU, Japan, and India for medical recognition and use of herbal and traditional remedies: A national commission (Commission S in the EEU, the Kempo Commission in Japan) evaluated them, producing an equivalent to the Physician's Desk Reference which shows the mode of action, side effects, potential adverse interactions, dosage, and proven "on label" uses for the substance. Any health practitioner can prescribe these, and the national health care system pays for them exactly as it pays for any other "on label" use of an approved drug. In the EEU, almost all M.Ds prescribe non-synthetic drugs for patients, and the savings to national health care systems for drugs is estimated to be as much as 80% because herbal and other natural drug compounds are on average even cheaper to produce than generic synthetics in standardized doses. Further, the rate of adverse side effects is notably lower with natural than synthetic pharmaceuticals.

Discussion: Management Theorist Peter Drucker, in his 1968 *Age of Discontinuity*, predicted that

new technologies would bring the age of dominance of the major industries and corporations of 1968 to an end. He was right. One casualty of this “turbulence” in business and industry dominance was the healthcare and pension system supported by employers. After World War II, American workers at big companies thought they had a deal: in return for loyalty to the companies workers would obtain job security, health care, and a dignified retirement. This deal was the basis for America’s postwar social order. Americans thought of themselves as rugged entrepreneurial individualists, superior to the coddled Europeans with their oversized welfare states that provided for healthcare and pensions to all citizens, however contributive to their societies. In fact, as Jacob Hacker of Yale points out in his book *The Divided Welfare State*, if you add in corporate spending on health care and pensions that is both regulated by the government and subsidized by tax breaks, the U.S. “welfare state” is about as large relative to our economy as those of European nations.

This U.S. system was imperfect, because those who don’t work for companies with good benefits are essentially second-class citizens in respect to health care. This fact was disguised by the fact that the vast majority of American workers and their families had health insurance through their employers until the 1970’s. Now a vast majority of employed people in the U.S. do not get health care benefits through their employers because they work part time, or their employers don’t offer such benefits; many more technically have benefits, but with such large deductibles and co-payments that these “insured” end up unable to pay their portion of health care costs generated by major illness or injury episodes. In Grand County, Utah, only about three in ten households has health insurance coverage through an employer; almost all of these are full-time federal, state, or local government employees. About one in ten households is under a public health “insurance” program like Medicare, Medicaid, or the state CHIPS program for poor children. The remaining six out of ten households have no health care coverage at all.

Those who have healthcare benefits through their employers are increasingly unprotected from bankruptcy due to their share of healthcare costs resulting from severe illness or injury. About half of all people who filed for personal bankruptcy in 2001 cited medical problems as the cause, and more than 75 percent of these had health insurance. Faced with rising premiums, employers continue to shift healthcare costs onto their employee’s shoulders. In 2005, health insurance premiums rose 9.5 percent, more than three times the growth in employee earnings. Premiums increased 13.9 percent in 2003. The Kaiser Family Foundation’s 2005 Employer Health Benefits Survey found workers paid an average of \$2,713 in premiums for family coverage in 2005, up nearly \$1,100 from 2000. Employee premiums averaged 26 percent of employer health insurance costs. Twenty percent of employers now make contributions to an employee HSA account rather than offering health insurance coverage.

Care for people with chronic health conditions such as diabetes, heart failure, asthma and hypertension accounted for 83 percent of all healthcare spending in 2001, according to Johns Hopkins University. By 2030, the Johns Hopkins study estimates half the adult population will have one or more of these illnesses. Almost 30 percent of those belonging to health maintenance organizations and nearly 25 percent of those in preferred provider organizations say it is difficult for them to obtain the care they need from the managed-care plan.

Supporting the health care system is a handicap on the competitiveness of U.S. exporters. In August, 2004, the *Wall Street Journal* reported a comparative international health care efficiency study which found that the U.S. health care system produced half the benefits in terms of lowered morbidity and mortality from injury and illness that the national health care schemes of the eleven other industrialized nations do. The *Journal* went on to editorialize that the embedded health care costs, e.g., \$5400 in every vehicle produced by General Motors, in U.S. products and services hurt their cost competitiveness on the international market. A study published in the *New England Journal of Medicine* found half of the U.S. adults studied failed to receive recommended health care. A health care system with high administrative costs and expensive high-tech care which delivers recommended care to only half of a nation's adults would predictably do only half as well in cost-effectiveness as a national health care system with low administrative overhead which delivered mediocre, low-tech services to the total population of another country.

Economist Paul Krugman editorialized in the November 28, 2005, *New York Times*:
“...instead of trying to pursue economic security through the back door, via tax breaks designed to encourage corporations to provide health care and pensions, we should provide it through the front door, starting with national health insurance.”

Numerous studies show that the portion of the health care dollar consumed by administrative costs is seven to ten times higher for private health insurance in the U.S. as it is in the national health insurance systems of other industrialized countries. As of 2007 consulting firm McKinsey & Co. calculates that each American spends \$728 on average for prescriptions, nearly twice the average for the industrialized world. The drug and health products industry has directed \$93 million to congressional and presidential candidates since 2000, according to the Center for Responsive Politics. An army of 1,100 lawyers and other lobbyists have spent over \$1 billion since 1998 on Congress, more than any other industry, to influence public officials and shape drug legislation.