Heritage Lectures
Published by The Heritage Foundation

No. 982
Delivered October 18, 2006
December 20, 2006

The Cure: How Capitalism Can Save American Health Care

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ROBERT E. MOFFIT, Ph.D.: Right now in the United States, we spend roughly $2 trillion on health care. We spend more than any other country in the world per capita: One out of every six dollars in your wallet is money that is going to the health care system. Pretty soon it will be one out of every five dollars, especially when the baby boomers retire.

Our health care system is in transition. It is unstable. It is unstable economically, and it is unstable politically. Economically, it is unstable because it is based on a system of insurance which is grounded in employment, and employment-based insurance in the United States is eroding. It is unstable politically because survey after survey shows that the American people are profoundly dissatisfied with the health care system, and majorities—at least in terms of their responses to the questions that are asked by the Kaiser Family Foundation or the Commonwealth Fund—will say that they are in favor of a massive overhaul in the system or major change in the system. Usually, the implicit suggestion is that they would like a system that looks like Great Britain or Canada or some other European country.

Roughly 50 cents out of every dollar that you spend on health care now is spent by the government, but in a very short time the baby boomers will start to retire. When the baby boomers start to retire, the Medicare expansion will start to go into high gear. The Medicaid expansion is already in high gear, and because Medicaid pays so much for long-term care,

Talking Points

- American health care is very expensive because we violated basic rules of insurance. We ought to expand HSAs, build in more flexibility, and level the playing field so that an individual can get the same tax preferences as an employer.
- The Federal Employees Health Benefits Program shows how persons can get better care through personal choice. Most Americans have a choice of exactly one plan provided by their employer. Federal employees have 284 nationwide.
- Medicaid, arguably America's worst government-run program, should be turned over to the states so that the states can experiment and innovate, just as they did with welfare reform.
- Overall, America needs to build on the principles of individual choice and competition. People need more choices of plans and more consumer-driven health care. Health savings accounts and high-deductible plans are steps in that direction.

This paper, in its entirety, can be found at:
www.heritage.org/research/healthcare/hl982.cfm

Produced by the Center for Health Policy Studies

Published by The Heritage Foundation
214 Massachusetts Avenue, NE
Washington, DC 20002–4999
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once again with the rapid aging of the American population, if there is no change in policy in Washington and in the states, that will be another massive expansion of government financing of the health care system.

There is the golden rule: He who controls the gold makes the rules. If the gold is controlled by the government, the government will make the rules, and you will do exactly as you are told. That's how it works. It's a law of nature. It's like the law of gravity: It's not something you can escape. That's the reality.

Dr. David Gratzer is a friend and a colleague—a very good friend and an outstanding colleague. He is a senior fellow at the Manhattan Institute. He is Canadian by birth, and he is a physician who has practiced in Canada. He has come as a prophet who has been to the other side of the mountain and says we ought not to go there; we ought to do something else. His interests include Medicare and Medicaid, drug reimportation—basically bringing drugs across the border from Canada—FDA reform. Milton Friedman, a Nobel Laureate and one of America's great economists, has said that Dr. Gratzer is a natural-born economist. Well, if anybody would know that, Milton Friedman would.

Dr. Gratzer is the author of *Code Blue: Reviving Canada's Health Care System*. He's also a frequent contributor to the Canadian publication the *National Post*. He's written for *The Wall Street Journal*, the *Weekly Standard*, the *Los Angeles Times*, *National Review*, and *Time Canada*. He is, of course, a member of the medical profession and also a senior specialist in health policy. He's a peer reviewer for professional journals, including the *Journal of Health Politics, Policy and Law*, the *Canadian Medical Association Journal*, and the *American Journal of Medicine*. He is married and the proud father of a new baby girl.

Ladies and gentlemen, welcome my friend and colleague from Canada, Dr. Gratzer.

—Robert E. Moffit, Ph.D., is Director of the Center for Health Policy Studies at The Heritage Foundation.

DR. DAVID GRATZER: Thank you very much for that overly kind introduction. I'm reminded of why a colleague from years ago had suggested that on paper I seemed like such an interesting person. I also want to thank you, Bob, for your help as I was putting together this book and for the help of your colleagues Nina Owcharenko, Ed Haislmaier, and others, who've done such important work. I very much appreciate your efforts here.

It was the best of American medicine; it was the worst of American health care. What do I mean? A one-inch incision, a 28-minute procedure, generating a bill that was a foot and a half long: That was my wife's experience with surgery in West New York. I'd invited my wife on a conference trip I went to in the mountains, and I thought this would be the most inexpensive trip of my life: The plane ticket was covered; the hotel was covered; there was really nothing to pay for.

Well, this turned out to be an enormously expensive inexpensive ski trip because my wife ruptured a disk in her back on the bunny hill. She needed some surgery. She was confined to the couch. She was in incredible pain. She was not the person she usually is: an active physician and mother.

So I decided to shop around and find a neurosurgeon in West New York. I went to the Internet, where you can find out everything about anything, it would seem, and found out practically nothing. I resorted to cold-calling neurologists and asking their technical opinion of a neurosurgeon. Finally, I found somebody who was willing to provide me with a little bit of advice, and we found a neurosurgeon. He offered us a choice of two hospitals; we had information on neither. I think we eventually chose one because the name sounded more reassuring; there was "Saint" in the title or something of the sort. Nothing bad can happen to you in a hospital with a Saint in the name, right?

The night before the surgery, we sat in a Hampton Inn that we had selected through hotels.com. We had a rating system for the hotel. We knew the price when we walked in. We knew everything there was to know of significance about the hotel: the AM/FM radio in the room, the fact that they had an outdoor pool—not that we would be doing

much swimming—and so on. And there I was in this West New York hotel mulling the dark choice that lay ahead. Here was the mundane decision I had perfect information on—the hotel—and the big decision—who was going to cut into my wife the following morning—I knew practically nothing about, nor the hospital he worked in.

Then, of course, there was the bill, which was a foot and a half long, and I was horrified. As a doctor, I can tell you I had no idea what was on the bill. I simply couldn't understand it. So I called up the hospital administrator and I said, "There seems to be an exceptional amount of money. Can we talk about it?" And she very reassuringly said, "Of course. Please consider this just a starting point of negotiations." Where in America do you get a bill and they start by telling you, "We don't even believe our own bill; don't worry about it"?

Before, by the way, we got into negotiations, I started to receive threatening letters from a collection agency. I called up the hospital administrator and I said, "Listen, give me the list price for Medicare. I'll add 10 percent and mail you a check this afternoon," and she said, "I can't give you the list price for Medicare." I said, "Why not?" and she said, "It's a secret."

Everyone I know has some story like this about American health care. Maybe not involving your wife, maybe not involving a ski slope, but involving the confusion—the prices that are inscrutable, the ever-rising costs, the questionable quality, the chaotic lack of information. That is the micro-level. Of course, as Bob alluded to moments ago, the macro picture is equally confusing. We now spend $2 trillion a year on health care in the United States: 16 percent of GDP. It is awesome how much health costs have gone up in just a short period of time—not in the last 500 years, not in the last 50 years, but in the last five years. The Kaiser Family Foundation recently released a report showing that health insurance premiums have doubled since the year 2000.

Incidentally, the average American worker, while labor costs are up, has not seen much increase in average family income, in part because health costs are swallowing it up. What to do about this problem? As you are well aware, some people are looking north for answers or looking over to Europe. Seventeen states in the last year have debated a single-payer option. California legislatures actually passed a single-payer bill, eventually vetoed by the governor.

That is the ongoing government temptation, and some people in the corporate world, in academia, in the union halls of America are looking north and seeing potential. Not me.

I learned my most important lesson in medical school not in the classroom, but on the way to it. I grew up in Winnipeg, which is in the middle of Canada. It's a city roughly the size of Indianapolis. On a cold winter day in Winnipeg, it can drop to 40 below. Needless to say, Winnipeggers are a hardy bunch, and all parking lots are outside.

So I parked my car that February morning and walked to the classroom. I wanted to take a shortcut because it was blisteringly cold outside, and I decided to cut across the emergency department as I had done before. I swung open the doors and walked in, and I discovered the emergency room overcrowding crisis that was plaguing so many Canadian hospitals in the mid-1990s. I stood there, and I remember the smell: the smell of sweat, the smell of urine, the smell of fear that hung in the air. Elderly people had been waiting four, sometimes even five days to get a bed. And I remember stepping into that emergency room and thinking to myself, something is desperately amiss.

When I grew up in Canada, I was interested in getting into medical school. If you had stopped me on the street when I was 16 or 17 and asked me about the Medical College Admission Test, I could have given you a variety of very satisfying, unique statistics on admission and so on. I didn't give a lot of thought to health policy. When managed care was debated in the United States, I remember vaguely thinking there was something good about the idea: After all, government should be involved in health care. I had never even been to Washington, D.C.

But when I stepped into that emergency room, it got me thinking. Again, I was a Canadian. There are three things I absorbed from that environment: One was a fondness for ice hockey, the second was an ability to convert Fahrenheit to Celsius in my head, and the third thing was a belief that if the

government did it when it came to health care, it must be compassionate.

Eventually, I began to think about these things. In Canada at the time, there were really two schools of thought with regard to health reform. There were the people who thought we should spend more—I like to call them the spendthrifts—and the people who thought we should just hire more administrators and make the system work better—I like to call them the magicians. I started to think about these things, and I became a spendthrift, and then I became a magician, and then I became agnostic, and eventually I became an atheist on health policy in Canada because I realized there was something going on which was much more fundamental: that there was a problem with a government-run system.

Maybe it was just the experiences I had, seeing a patient who had a minor hernia repair and a neurofiber was caught and needed to be referred to a pain clinic; unfortunately, there was a two-year wait list. A gentleman with the classic symptoms of sleep apnea needed to go to a sleep disorders clinic and get a test: three-year wait list. My father, who could barely walk—classic symptoms of spinal stenosis—was told he needed an MRI and told he should wait eight or nine months.

These were the things I came into contact with, and I rethought my beliefs. I started to write articles on this and the problems in Canadian health care, but there's only so much you can say in 700 words, so I started to write a longer piece. I told my parents, and they were very supportive about the idea, but I'm not sure they thought I would get my book published.

I initially approached 12 publishers and got 13 letters of rejection. One publisher lost my sample chapters. They rejected the proposal. Then they found the sample chapter, and it was just as bad as they thought it would be, so they sent me another letter of rejection. Eventually, I got the book published, and it went on to win the Donner Book Prize, which is a prestigious award in Canada.

What I discovered was how many Canadians were realizing that there was a problem in the system. Maybe our politicians weren't willing to talk about it, but they themselves could appreciate that something was not right in Canada. Eventually, people spoke out about this. Canadian politicians are a very cautious lot and continue to not really speak at great length about these things, but the mood had suddenly shifted.

Today, things are very different than they were even a short time ago. A private clinic opens up at a rate of about one a week in Canada. One of the foremost critics of Canadian health care is a doctor who was just elected president of the Canadian Medical Association. Even the Supreme Court of Canada recognizes something is desperately amiss; just last year, they ruled in a case that access to waiting lists is not access to health care, and this undermines some fundamental constitutional rights that Canadians had, and they struck down key laws in the province of Quebec.

Canadians are beginning to rethink their system. You find the same thing across Europe. Yet here's the irony: If Canadians are willing to rethink things and embrace, at least to some extent, some capitalism when it comes to health care, I find increasingly that Americans are not. If Canadians are willing to rethink these issues, Americans are also rethinking and heading down the same lines that Canada once did. That's a terrible mistake and part of my motivation for writing this book.

Let's shift gears for a moment and ask a simple question: Why are there so many problems with American health care? Here is a very simple answer: Americans are not *under*insured; they are *over*insured. As a result of this, American health care is so terribly expensive because it's so terribly cheap. I think can explain to you everything about American health care in four dates, touching on two people and one organ. Let me start on that.

February 12, 1941: the first clinical use of penicillin. That is really where the era of modern medicine begins. I think a lot of people tend to think of medicine as this ancient tradition. Certainly, doctors like to play up that myth. Doctors always emphasize the Hippocratic Oath. At the end of medical school, one takes the Hippocratic Oath. My medical school was particularly keen on Hippocrates; we took the Hippocratic Oath twice—once at the beginning of med school and once at the end, in case you'd lost your morality over the four years.

But medicine is a thoroughly modern creation, and it begins on February 12, 1941. A lab in Britain, primarily for research purposes in the heat of the war, decided to do something more practical. They thought there was something up about penicillin, a controversial idea, and they picked a person who was dying of a simple infection: Alexander Albert had reached down to pick up a letter off the ground and scraped his face on a rose bush. It became infected, and within a few days he was on the sepsis ward of the local hospital. Sepsis is the blood infection that follows a superficial infection.

Mr. Albert was literally dying of this infection. They gave him a dose of penicillin, and nothing happened. On day two they gave him another dose; nothing happened. On day three they gave him a third dose, and his fever broke. On day four he was up and eating again; on day five he was palpably better. All we understand about modern medicine really begins with this first day.

Dick Cheney, the Vice President of the United States, has had four heart attacks, which, if you step back, is an incredible number. One measure of how functional a heart is is to look at ejection fraction. The heart is effectively a pump, and one can look at how well that pump functions. I'm a relatively healthy individual; probably the ejection fraction of my heart is about 70 to 75 percent. I've had a lot of espresso today; it's probably a little bit less efficient as a result. The ejection fraction of Dick Cheney's heart was 25 percent. Dick Cheney is running around with less than half of a heart.

Isn't it remarkable that in such a short time, something like heart disease could be revolutionized? Let me give you some statistics. Death by cardiovascular disease has fallen by two-thirds over the last 50 years. One of the people I spoke to as I was writing this book is a cardiologist who is working at a Harvard-affiliated hospital. He told me that the very nature of heart disease has changed, that the person walking into the emergency room today who has had a heart attack has probably had a couple before; he's probably in his 70s. Just a short time ago, that wasn't the case.

One thinks of the advances that have occurred in medicine and, again, pauses and appreciates how recent they are. General Robert E. Lee in 1863 has a heart attack on the battlefield. What is state-of-the-art cardiac care in 1863 if you're a really important guy in America at the time? Bleeding? Out of fashion for at least 30 years. Bed rest? How long? Two weeks exactly.

Winston Churchill, shortly after the bombing of Pearl Harbor, comes here and gives one of the greatest speeches of his prime ministership. Then he gets on a train to go to Canada to give an equally rousing speech in Parliament, but on the train he discovers the window is stuck. He wants some fresh air, and he's straining and straining. Suddenly, he gets crushing chest pain radiating to his left arm. He's having a heart attack. What is state-of-the-art medicine for the Prime Minister of Britain or anyone else in 1941? Bed rest. Six weeks. That is a century's worth of medical progress: from two weeks' worth of bed rest to six weeks' worth of bed rest. One can look at other prominent people: Dwight Eisenhower and so on.

All of a sudden that changes in 1941 with penicillin. Had we discovered nothing else in the 20th century, I'm still convinced it would have been the century of medicine, but so much else follows: steroids, beta blockers reducing cardiac mortality—one pill by 50 percent—antidepressants, antipsychotics. So many things come about in such a short time that you can be a person riding on a bunny hill and do severe damage to your back, and a few months later you're back in the family doctor's office seeing patients, as was the case with my wife.

So medicine is much better, and that's where most people end their story. They say you're paying more than you've ever paid before; progress costs money. Dick Cheney has a pacemaker plus in his chest, which is a special type of pacemaker, and it costs about 50 times more than the average expenditure on health care in 1950. Medicine has never been better. Medicine has never been more expensive. People like David Cutler put forward that argument.

I don't buy it, because in every other aspect of the economy, technological advancement has been accompanied by a fall in prices. Look at unit price. Computers are much more sophisticated than they

were 10 years or 20 years ago. The computer on my desk is faster; I can download stuff from the Internet—whatever I want. It's so much more sophisticated, and yet it's so much cheaper. Look at the macro level: Agriculture is much more sophisticated than it was 50 years ago. We feed more people a more diverse amount of food, and yet as a percent of GDP it has dropped.

Why is it that health care keeps rising year after year? Why has cost doubled since 2000? I think, unlike so many of my colleagues, the answer is because of the odd way we pay for health care in America.

How do you understand health policy? Two dates: October 26, 1943, and December 1, 1942.

October 26, 1943: possibly the most important day in health policy in America. The Supreme Court does not issue a ruling; Congress does not pass any legislation; FDR does not even give a rousing speech. The IRS rules for the first time that employers can provide health insurance and pay the premiums in pre-tax dollars. That eventually gets codified in 1954.

How did this come about? Wage and price controls during the Second World War. Everyone knows the story about price controls. Perhaps some of the older members of this group have lived through it; perhaps you simply heard stories from your aunt or grandmother talking about rationing butter and so on. Everyone remembers the price controls, which were quickly abolished; few remember the consequences of wage controls. Employers all of a sudden needed to attract employees but couldn't offer better wages. So they started to offer benefits, and in particular, they offered health insurance, something employers really hadn't done before the Second World War; and what was a fringe benefit initially became the mainstay of private insurance for Americans after October 26, 1943. All of a sudden you could entice employees with health insurance.

Why did that make sense from an employer's point of view? Wage controls. Now you could offer them a benefit in pre-tax dollars; you got around wage controls. But for employees, it was also a good deal. Think about it: If your boss offers you $1,000 in bonus, how much are you really going to take home? Depending on what the marginal tax rate is, depending on your bracket, you might only take home $500. But he offers you $1,000 worth of health insurance, and you could potentially take home $1,000 worth of benefits. That is why, well into the 1970s and '80s, employers offered health insurance and lots of it; why sunglasses, marital counseling, hair transplants were all at one point in time covered by health insurance. All of these things are important, but they aren't really insurance as we understand it in other aspects of the economy.

December 1, 1942: Lord Beveridge in London issues his report on public health insurance, and he points out that the most compassionate way of doing it—there's that word again—is a zero-dollar insurance. Lord Beveridge obviously has huge influence in Britain, but his ideas have resonance across the Atlantic. Part of it is because the Democrats are floating their own ideas on health insurance; part of it is that Lord Beveridge is an enormously charming and persuasive individual. He goes on a speaking tour across the United States. He persuades Members of Congress, Senator Robert Wagner of New York, Senator Harry Truman of Missouri. His ideas fall apart before Congress, but eventually I think they gave the intellectual foundation for Medicare and Medicaid, which also, at least in the American experience today, is pretty much a zero-dollar insurance. Medicare isn't quite like that in part B, but allow me a little bit of latitude.

The end result of those two days 60 years later—long after the war has ended, long after Lord Beveridge has retired and gone to his reward, long after wage controls have been abolished—is that Americans are just hopelessly overinsured when it comes to health insurance. For every dollar spent on health care in the United States, only 14 cents comes out of pocket. That applies for people on Medicaid, Medicare, privately insured, and that's why we have such an upside-down universe when it comes to health care.

I alluded to the lack of transparency with hospital pricing. I've actually found transparency in hospital pricing in America. My daughter, who is rather young, has a fondness for dolls, so I bought

her an American Girl, the Itty Bitty Baby. As I was recently on Fifth Avenue, I went into the American Girl store, and on the second floor they have an American Girl hospital, and they have a price list. If your American Girl doll needs a cast, it's $25—no insurance taken, unfortunately—but that's really the only price list one finds with hospitals in America.

So many other problems exist with regard to transparency and prices. Why? Because Americans are uninformed. They don't ask the same sort of questions they would ask with food, clothing, and shelter.

How do I think we ought to proceed? There is a fourth date I think you need to bear in mind: January 1, 2013. Why did I pick this date? If you think we have problems with health care today, you haven't seen anything yet. We spend about $2 trillion a year on health care in the United States; by 2013, reasonable projections are that will rocket up to about $4 trillion: 16 percent of GDP today will rocket up to about 21 percent of GDP.

In other words, if companies like GM and many other companies are having trouble paying for health care today, you ain't seen nothing yet. 2013 is also remarkable, as Tommy Thompson recently pointed out to me, because it's the year when Medicare starts drawing from the Treasury instead of shedding dollars. So if you're a government official, or you follow government officials like my colleagues here at The Heritage Foundation do, then you know that the Federal Treasury is a little bit strained already.

There's more trouble to come. Everything we know about American health care is about to change.

I've only really found three choices for America. How can we deal with this financial crisis? One: Go back to managed care. Health spending largely plateaued in the mid-1990s. Sure, people were upset, but we actually contained costs.

Option number two: socialized medicine. Every other Western country has done it. You want to call it universal health care; you want to call it single-payer; whatever you want to call it. Steffie Woolhandler calls it the "cure." I don't.

Option number three: Let's try something we don't do a lot of in health care policy in the United States: capitalism. Let's do for health policy what we've done in the other five-sixths of the general economy.

What do I think about managed care? Overly paternalistic. I don't think it jibes with American values. What do I think about socialized medicine? You've already heard what I think about socialized medicine. That really leaves us only with the third option, something we have to move on now. How would that look in terms of actual reforms? There are basically five steps that I think we ought to take now and that Congress needs to act on and the President needs to sign into law.

First of all, we need to make health insurance more like every other type of insurance. As I've alluded to before, Americans are overinsured because, in a sense, many insurances don't discriminate between small items and large items. Imagine if we did that for car insurance. It wouldn't just cover you if you were in an accident, but it would cover you if you had a fender bender or your tank of gas was running low or your wife couldn't believe you bought a blue car and thought you should get a paint job to make it a red car. Car insurance would be feverishly expensive were we to adopt that approach. American health care is so very expensive because we violated basic rules of insurance.

What does that mean? I think Congress took a good first step with health savings accounts. I think they are overly rigid in their structure: something that made sense for a tax committee of Congress and not so much on Main Street of America. I think we ought to expand HSAs; we ought to build in more flexibility. I also think we ought to level the playing field so that if you're an individual, you can get the same tax preferences as an employer.

Idea number two: Government policy needs to foster competition. It seems absurd to say that in America, but so much of our philosophy has been "regulate first, ask questions later" for the last 60 years. Let me just give you one example.

As you know, I'm affiliated with the Manhattan Institute. Sitting in my office in New York, if I tried to buy myself health insurance, I would pay four times more than I would pay for the exact same insurance policy from the exact same company if I

lived in Connecticut. That's because New York State has thrown in so many mandates—44 in all—as well as guaranteed issue and community rating, meaning you can buy health insurance in New York State after you get sick, which is like buying home insurance after your house has caught fire. We need to deregulate that and, in lieu of that, allow out-of-state purchases.

Many federal and state laws also undermine competition: EMTLA,[1] certification of need laws, and so on. We need to reconsider that if you want competition in the quality of innovation.

My third idea: We need to reform Medicaid. Medicaid has become the great sleeper issue. We spent $5 billion in 1970; today, we spend over $300 billion a year, in part because it is owned by neither the state government nor the federal government and, as a result, is probably the worst government-run program in America.

How to reform Medicaid? Turn it over to the states. I favor block funding, much in the way we reformed welfare a decade ago. Let the states experiment and innovate. Let's look forward to one day having a Wisconsin for Medicaid the way we had a Wisconsin for welfare reform.

Idea number four: We have to revisit Medicare. We've had a lengthy and feverish discussion about a prescription drug benefit, but we really haven't seriously reformed it in any way, shape, or form. As Bob likes to point out, when the foundation of the house is weak, we've built a gazebo and gotten a second mortgage for it. I thought this debate was further ahead a decade ago when we were talking about a menu of private insurance options modeled after the Federal Employees Health Benefits Program. I don't think this is a cure-all, but I don't think we can even look at solving our Medicare crisis until we get away from wage and price controls, which has been among the reform efforts of this Administration and every other Administration since Medicare was created and Nixon refurbished it.

Finally, my fifth idea is we have to look at prescription drug prices, which I think everyone can appreciate are too high. The way to do that is to go back and reconsider the role of the Food and Drug Administration. That's my plan.

For 30 years, we've dealt with rising health costs, and there are two titans who have come out of this era. There is Wilbur Mills, who championed Medicare and Medicaid and I think more than anyone else got that through Congress, and Richard Nixon. Wilbur Mills said expand government, and that will solve your problems, and Democrats have dutifully followed. Richard Nixon said we need to do something, and he preached a corporatization of American health care, particularly like managed care, HMOs, which before then were just a West Coast idea.

I don't think, fundamentally, those two visions are going to work. I think the problems with American health care are going to grow with time, and thus we need to look at that third option, that crazy option that so few people are willing to embrace but that we've embraced for the other five-sixths of the economy. That is what I talk about in my book.

Questions & Answers

QUESTION: Could you discuss briefly the role of the FDA and what you would like to see for the FDA?

DR. GRATZER: One has to look at the role the FDA plays in terms of safety and efficacy and how they go about doing that. I like some of the experiments that went on during the Administration of the first President Bush, where they outsourced to not-for-profit companies part of the FDA approval process. I noticed that the approval times were shorter and the results were the same as when handled by the FDA.

The FDA is a great turn of the 20th century American institution; unfortunately, we're in the 21st century. If another country approves a drug, does the FDA need to be as diligent as they have been? Much focus on the FDA is safety. Wouldn't it be refreshing if we had a Senate committee look into slow drug approval? A drug comes to market, and the FDA officials tell us this will save 10,000 lives a year, and it

1. Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd.

took them seven years to approve the drug. Maybe some lives were lost in the process.

Most Americans want a market for medical progress. They want innovative drugs. Medicine has dramatically changed in the last number of decades, and yet, as a practicing psychiatrist, I can tell you the enormous frustrations of working today. With schizophrenia, we have better drugs than we've ever had in our history, and yet so many of my patients can't be helped. If you had a relative who is aging, you know the horror of Parkinson's or Alzheimer's. One could go through a host of other illnesses and cancers, and so little progress has been made.

The FDA should go back to its original pre-1963 mandate of certifying safety. I think the focus on efficacy is a mistake. That rose out of the Thalidomide scandal—which, incidentally, had nothing to do with efficacy standards of the FDA. It adds about 40 percent to the cost of a drug. I also think it gives us a host of information that a lot of people don't use. In other words, if we throw up all of these hurdles, and we're not getting any more information, and it drives up costs by 40 percent, what are we doing? I think ultimately what we're doing is creating a drug cartel in America where seven or eight companies can bring a drug to market. Ultimately, we're all losers for it.

QUESTION: Being a former civil servant and having an excellent health care plan for my whole career and even after retirement, like all civil servants and Members of Congress, we are accustomed to paying very little and getting excellent care. It seems there is a huge obstacle to overcome here. Until you get beyond that and have Congress really understand that this benefits them and only a small percentage of the public, I'm not sure how you get that message across that things have to change. It's so good for those who are making the laws.

DR. GRATZER: The Federal Employees Health Benefits Program: We need to really study it. Bob Moffit has done masterful work in this area. It's a model for better care and choice. Most Americans have a choice of exactly one plan provided by their employer. That's not a lot of choice. Federal employees have 284 nationwide.

DR. MOFFIT: Even more significantly, only 23 percent of the American population has a choice of carriers. In other words, you get a health plan at a place of work, and it's one health insurer: You might have a choice of two or three plan options, the standard HMO or PPO, but it's offered by the same company. So you often have two or three flavors of vanilla, the same networks of physicians and medical institutions. Federal employees have 11 carriers nationwide with 19 plans nationwide. So whether you're in rural Montana or downtown Chicago, it doesn't make any difference; you have access to those different plans.

DR. GRATZER: To get back to the larger question, if Congress is so well served by this and there's been so much gridlock in Washington, how are we going to get past this? I recall Herb Stein's law of economics. He should have won the Nobel Prize for economics for this simple observation: That which cannot go on forever will eventually stop.

If health costs spiral from $2 trillion to $4 trillion, there's going to be incredible pressure on Congress to act. Sure, "Health Care Week" came and went this year in the Senate without a single bill being voted on, but the cost pressures are great and are going to be great whether or not we have a Republican Congress or a Democratic Congress or a split Congress. The question is only which of those three options we're going to embrace.

I don't think Americans want the paternalism of managed care; socialized medicine is a disaster wherever it's been implemented. I know. The only option is more choice and competition—like the choice and competition that federal employees have.

QUESTION: People who favor the socialized, government-run health care approach usually say that health care won't really work as a market. They point to the fact that about 80 percent of health care expenditures is consumed by about 20 percent of patients in any given year and that so many costs are going for catastrophic care that you can't really have the type of competition that leads to innovation and keeping prices down. What is your response to that?

DR. GRATZER: The 20/80 rule: 20 percent of the population accounts for 80 percent of the cost.

People say, "Look, that just shows you that the minority are sick and they chew up all the health care dollars." I don't interpret it that way. Let me give you an example. My wife had a baby, so for that year, our health expenses were very high; the following year, they were not. So I don't think you're looking at chronic illness simply chewing up all of the health dollars. That doesn't undermine the need for a market.

Second, competition and innovation and more catastrophic health insurance is very important, even for people who are chronically ill. Who is worst-served by the system where it's basically a black box? If you're a diabetic, where do you take your health care dollars? Today, there is so little information, and that serves people with chronic illness so poorly. The people best served by health savings accounts are going to be the people with chronic illness.

Let me give you one example: Very shortly, one drug company is going to have approved by the FDA an aerosolized insulin. It changes the very nature of diabetic care: No more needles; you can inhale your insulin through a puffer. I suspect that several insurance carriers will not want to cover that in their drug plan, but if you had a health savings account and you were a diabetic, you could spend it where you please.

Innovation and competition are critical in this area, not despite the chronically ill but because of the chronically ill. So many of these statistics just confuse the issue. Forget about the debate; look at the marketplace. Some companies like Whole Foods are endorsing and embracing consumer-driven health care. Their health inflation numbers are much lower than other companies' numbers.

QUESTION: With last year's Canadian Supreme Court ruling and the new private clinics opening up in Canada, can you talk about what form you would like private insurance to take in that country?

DR. GRATZER: Canada is going through incredible changes. One sees that as well in Britain. What are some examples of that? A private clinic opens at a rate of about once a week in Canada. In Britain, a Labor Party that created socialized medicine in Britain announced last year that they would quadruple the number of surgeries contracted out to the private sector. In Sweden, most primary care will now be contracted out; the largest hospital in Stockholm is now privately run. Even in Slovakia, which was previously a Marxist country, they are looking at market reforms.

Things are changing dramatically. Whether you're in Stockholm or in Slovenia, one sees the ideas of Adam Smith percolate.

How do I think these countries ought to go forward? The economics there are not profoundly different from the economics here. People are over-insured. In Canada, you pay practically nothing to access primary care; you pay practically nothing to access hospital-based care. Why do I say practically nothing? By law, it should be nothing, but hospitals cheat. So you break your leg, and you want something fancy like a cast, and they'll charge you $20 as though that were medically unnecessary.

Those countries need to reconsider what's covered, when they're covered, and whether or not there are co-pays and deductibles. There's been progress in Canada. You can get a private surgery in Quebec; you can go out to the west coast and get many surgeries. But there's so much more work to be done, because the concept of a user fee in Canada and Britain is still unmentionable. Reform efforts are still pretty young.

QUESTION: In the House of Representatives about a month ago, there was a discussion about proposing a block grant program for the states. They had a person who obviously wanted a single-payer system and also somebody who wanted a free market like what you're advocating. Have you heard about that?

DR. GRATZER: Sure. You'd offer a policy "toolkit" to the states, and they could experiment. I'm not opposed to that idea. If a northeastern state wants to be an example of a single-payer health care system, that might well be more useful to the public than dozens of my speeches on the topic. The states should have more flexibility. Congress has done so little to promote flexibility.

The lowest-hanging fruit is Medicaid because of the cost crisis. States now spend more on Medicaid

than they do on K–12 education. It would be relatively easy to block grant it. So many governors, Republican and Democrat, are terrified of the costs of long-term care. One wonders whether, if you took that out of the equation, if that would be useful. So I'm in favor of experimentation: at the employer level, at the individual level, at the state level, and at the federal level.

Ultimately, the answers are going to be found in free-market principles. If Maine wants to expand Medicaid and cover everyone and anything, including domestic animals, I think they should have the right to do it. I'm not sure the federal government should subsidize it, but I think they should have the right to do it. Likewise, if Arizona wants to take a free-market approach, that's reasonable. As Sherlock Holmes once said to Dr. Watson, "Eliminate all other factors, and the one which remains must be the truth."

QUESTION: Socialized countries are trying to experiment with more privatization in their systems. Why do you think that there is such a lag among Americans catching on that these socialized systems are actually turning to capitalism?

DR. GRATZER: It's one of the very few American debates where prominent people are convinced that America's got it wrong and other countries have it right. We don't look at France and say, "High taxes seem to work for the French." Canada—cold, high taxes, bilingual policy—we should embrace that?

Health care is one of those fields where everyone is dissatisfied, and unfortunately, because there is a private sector in America, some people have concluded that the problem is really with the private sector rather than with the public sector. I emphasize that this is not a private system. This is a quasi-socialist system, as Bob noted, and for every dollar spent on health care, roughly 50 cents comes from the government in one form or another. With the tax subsidy, you could argue government spending is even higher. And with regulations, the influence of government, the shadow of government over the system, is even more profound.

That is what we need to attack. The concept of consumer-driven health care is quite exciting, and Congress took the right step with health savings accounts. This is an exciting time, and this is a very dangerous time. It's like a Latin American country voting out their socialist party and voting in the capitalists. The capitalists can do one of two things: They can embrace free-market reforms, and the country will flourish. Or, more often than not, they appoint their cousin to run the state pension plan; he steals everything, and capitalism just means crony capitalism.

We need true free-market reforms, not free-market reforms in name only. But I also think that just talking about what goes on in those countries is useful.

QUESTION: Concerning the consumer-directed health plans, a lot of the discussion seems to hinge on the idea that insurance will continue to be provided by employers, but a lot of people are starting to think that in 10 or 15 years that may not necessarily be true. Even behind closed doors, labor unions and people you wouldn't expect will say it quite frankly. In light of that fact, how exactly would a reform program work?

DR. GRATZER: Most Americans still receive their private insurance from their employer. The statistics already aren't very good: Between 2000 and 2005, the percentage of companies offering plans has dropped from 69 percent to 61 percent. Large companies have not dropped coverage, and as a result, the total percentage covered by an employer plan hasn't precipitously dropped.

This concept made sense when wage controls were implemented during the Second World War, and people tended not to move a lot between companies. You were born in Hershey, Pennsylvania, you went to work for Hershey, you went to the Hershey swimming pool and the Hershey Country Club—if you were in the higher echelons in the company—and you retired to your Hershey pension plan. You might have even lived in a Hershey-built house. In such a day and such a time, health insurance provided by the employer made a lot of sense.

Most people in small and medium-sized businesses turn over about once every 15 months, according to Labor Department statistics. We have a much more mobile workforce. It shows you the enormous limitations of health insurance that isn't mobile. Again, health savings accounts somewhat address

that, because the savings you can take from job to job. In the short term, we need to build a market.

Concerning the employer-based system, one has to remember the enormous indirect subsidies the system gets. The health tax exclusion provided to employers for their employees is a larger tax write-off than even mortgages. People talk about tax reform time and again, and they don't talk about the health tax exclusion. You're not talking about tax reform.

What do I think we ultimately need? Moving insurance away from employers, having a simpler tax code, letting people get their insurance maybe through their church or their synagogue or their union. Those are all reasonable ideas.

Unfortunately, a lot of government law and regulation stands in the way of proper pooling. Part of the reason the Federal Employees Health Benefits Program works is that you've got a lot of people enrolled: about 8 million people. If a union wanted to sponsor health insurance or a church wanted to sponsor health insurance and millions of people enrolled, good things would happen. Those are the sorts of things we need to talk about, because I don't think the existing system is going to survive.

QUESTION: What do you think about the actual number of uninsured? As we try to estimate costs for proposals, it always hinges on that number. That number is highly skewed for some of the reasons that you just mentioned—a mobile force. They count structural unemployment that might last a month or two as being uninsured for the year.

DR. GRATZER: Those numbers are hopelessly skewed, but they make for great sound bytes. There are really only two numbers you need to know about American health care: 47 and 18. Forty-seven million don't have health insurance; 18,000 die every year according to the Institute of Medicine. But when you look at the numbers close up, you realize how misleading they are: 47 million Americans don't have health insurance, and yet a third of them have incomes of over $50,000 a year, a third of them already qualify for Medicaid, and a third of those remaining turn over quite quickly and gain coverage when they gain employment.

Am I suggesting that there is no problem with the uninsured? I am not suggesting that. By the way, the Institute of Medicine number is also misleading and unhelpful. We have to get the diagnosis right in order to get the treatment right. If 47 million people don't have health insurance, that doesn't automatically mean we need a government solution. You go down the wrong path. If we say people fall through the cracks, we need to reexamine that, but we need to be on the right path.

There is that core group of uninsured, the working poor, who go year to year without insurance. When they get sick, there are huge federal and state monies that are spent on them. We're looking at about $40 billion a year. One thing I like about the Massachusetts plan is that they turned some of that money over—the disproportionate share money, to use the technical term—into a state fund to help subsidize private insurance for the low-income uninsured. We'll see what happens with that.

QUESTION: General Motors has been running around the Hill trying to get the Congress to bail out their health care costs by proposing a federal reinsurance program, and eventually some insurance companies will jump on board because they have the exposure. What are your thoughts on that?

DR. GRATZER: GM has enormous problems. George Will recently wrote that GM is no longer a company; it's a welfare state. GM is running into enormous problems because of the very lavish benefits that they agreed to in union negotiations over the years. There was, I think, a Mercer study suggesting that if GM opted for a health plan, say, that Ford had, they would save $1 billion a year. So we're not talking about scrapping their health plan entirely, but just moving to another, frankly, lavish plan, from their gold-plated plan to their silver-plated plan.

Don't get confused by saying that the problems of GM are the problems of America. They negotiated those contracts; they'll have to live with the consequences of that and their share price too. And the solutions that they are focusing on are not helpful. They just want someone else to pay for it.

You saw that dynamic already with the prescription drug benefit. If you talk to people on the Hill close to that debate, they will tell you that rank-and-

file Republicans were never bullish on the prescription drug benefit. They were afraid of government cost overruns and the like—rightly so. Pharmaceutical companies were never terribly excited about it because they thought it's a back door to price controls. The people who pushed it the most were big companies like GM who have all these retiree benefits they can't afford. So what do you do? You push the costs over to the federal government.

We need to resist that temptation. There is a coalition growing in America, starting small but growing in its momentum, of corporate CEOs who don't want to pay health costs, union leaders who worry about health costs, and the activists and analysts of the Left. They simply want someone else to pay the tab. The obvious target is going to be the federal taxpayer. Be careful of socialized medicine creeping up on you with the best of corporate intentions.

QUESTION: I understand how a managed care system works, how a single-payer system works, and how a universal insurance system would work. I'm not clear yet how you would describe a capitalist system in other than those three terms.

DR. GRATZER: We need to build on the principles of individual choice and competition. In so much of American health care, you don't see that. People need more choices of plans; we need to move to more—and I hate using this term because it's now overused—consumer-driven health care. Health savings accounts and high-deductible plans are steps in that direction.

We also need to reframe government programs. Medicaid is a classic example of what not to do. In Vermont today, a family can earn $55,000 annually and still qualify with their kids for some type of a Medicaid benefit. If you're in New York and you have a clever lawyer and you're extraordinarily wealthy and have two Mercedes in your driveway, you can still qualify for Medicaid long-term care. This is silly public policy.

Look at other aspects of the economy and ask yourself: Why do those work so well? Why are we not having a discussion today on the crisis in food costs or the crisis in clothing? No, we're having a discussion instead on the crisis in health care.

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