We Need Medical Rationing? It Just Ain't So!

BY DAVID R. HENDERSON

In a recent op-ed in the *Los Angeles Times* ("A Health Care Prescription that's Hard to Swallow," January 30, 2006), Henry Aaron, a well-known health economist at the Brookings Institution, made the following argument:

Spending on health care in the United States is rising as a percent of GDP and could go from its current 16 percent to as much as 33 percent by 2030. Because higher taxes will be needed to pay for projected increases in Medicare and Medicaid, the government should ration health care, that is, restrict purchases of costly medical equipment, put caps on hospital budgets, and enforce protocols on treatments for various ailments—in other words, forcibly prevent people from getting certain treatments.

But Aaron's drastic political solution does not follow from his statement of the problem. In fact, Aaron does a sleight of hand that, unfortunately, probably far too few readers caught.

Aaron is right to say that we need to rein in government spending on Medicare and Medicaid. Socialized medicine for the elderly and the poor was never a good idea, and measures to limit such spending—higher co-pays, lowering the income at which someone can qualify for Medicaid, and raising the age at which people can qualify for Medicare from its current level of 65—make sense. Indeed, phasing out both programs makes sense and is justified on moral grounds also: forcibly taking money from some to pay for others' health care is wrong. It's even harder to argue for forcibly taking money from workers to pay for the health care of the elderly, who are, in fact, the second-richest age group (measured by wealth rather than income) in America.

But how does Aaron get from the fact that an unchecked Medicare and Medicaid will require higher taxes to his conclusion that health care should be rationed for all, including those who have their own insurance or who pay out of their own pockets? He doesn't tell us. Aaron seems to believe that because the growth of Medicare and Medicaid should be cut, it's only fair to limit what others can spend on health care also. If this is his argument, would Aaron apply it more generally? Under some states' welfare programs, for example, welfare recipients are not allowed to own cars. Would Aaron argue that as long as such restrictions remain, people *not* on welfare should not be allowed to own cars? I doubt it.

We are led to conclude, then, that in Aaron's mind, health care is special. What makes it special? He doesn't say, but we can speculate. Perhaps Aaron thinks consumption of health care should not depend on people's income or wealth, and so he wants government to prohibit you from spending your own money as you see fit in that regard.

Aaron could have made another argument for why health care is special. The U.S. health-care market, contrary to what many people assert, is one of the most regulated industries in America. In all states the supply of doctors and drugs is regulated by laws that raise prices and make many drugs unavailable. Hospitals and health insurance, which is how most people pay for health care, are also highly regulated.

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Aaron points out that insured patients "pay little of the cost of their own care when ill." Thus they "want everything that might conceivably add even some tiny benefit," no matter the cost. But when insuring my house, I would want every little benefit, no matter the cost, as long as I didn't have to pay for it. Yet no one is pointing to a house-insurance crisis. Why? Because the companies that sell us house insurance have clear-cut lists of what they will pay for and what they won't.

The same applies to health insurance, with this crucial difference: if the insurance policy covers a particular ailment, the law requires the insurer to provide any benefits that are "medically necessary" for treating it. The law is generally interpreted broadly to cover all the latest treatments, no matter how expensive. This means that an insurance company in the United States cannot offer a "Chevrolet" policy for dealing with, say, kidney disease; if the policy covers kidney disease, it must be "Lexus" coverage. Yet, arguably, a huge percent of the uninsured would gladly pay a substantially lower premium for "Chevrolet" coverage rather than go without. One could even imagine people being willing to pay low premiums to get "Canadian-style" coverage, which, in automobile terms, is a Yugo. Canadians and Americans are not that different. A sizeable percent of the Canadian population has become accustomed to, and apparently comfortable with, waiting months between diagnosis and surgery, even for such important things as heart disease and lung cancer. Possibly, some of the push in America for Canadian-style health care reflects many Americans' desire to pay less and get in a queue. So let them.

I don't advocate *imposing* Canadian health care; I do advocate *allowing* it. Yet regulations prevent it. And one good side effect of allowing Canadian-style health care is that it would reduce the size and power of the coalition that is pushing to impose that system on all Americans. The root of the problem that Aaron identifies is regulation that prevents buyers and sellers from making mutually beneficial exchanges: this regulation puts government in the role of dictating what can be bought and sold.

Missing the Logical Step

Aaron points to the inevitable result of patients paying such a small percentage of their health-care costs. But he doesn't take the logical step of suggesting that Medicare and Medicaid patients pay a higher percentage. Why limit their choices with a heavy-handed, one-size-fits-all mandate from above when a simple change would save the two programs' budgets and allow patients and their doctors to choose which treatments are worth the price and which aren't?

And here's the irony. The plan Aaron advocates looks quite a bit like Canadian-style health care. Restrictions on purchases of medical equipment, caps on hospital budgets, and enforced protocols on treatments—these are all important parts of Canada's socialized system. Aaron writes that politicians insist "they will fight off efforts to deny the insured any beneficial service that insurance covers." In other words, Aaron seems to understand the problem: government regulation prevents insurers from making sensible attempts to offer less-generous insurance policies. But rather than advocate allowing less-generous insurance policies, Aaron takes an even more drastic step of advocating forced rationing. In other words, rather than advocate a modest policy that goes against the current political mindset, Aaron advocates a drastic policy that goes against that mindset. Is it possible that Aaron has a romantic attachment to government control and regulation and that this attachment prevents him from seeing the solution clearly?

Finally, Aaron's implicit assumption that it's bad to spend 33 percent of GDP on health care is unfounded. If the incentives are right—so that people are spending their own money on health care or health insurance, are not subsidized to do so, and are allowed less-generous health-insurance policies—what's wrong with spending 33 percent of GDP on health care? If spending 33 percent of your income every year for the next 20 years would save your child's life, would you do it? And if you would, what would you think of someone who tried to stop you?