

Health care

Running for cover

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Fixing America's troubled health system requires taming the twin demons of cost and coverage. Which to tackle first?

Illustration by Sarah Hanson



AMERICA offers the best health care in the world. If you are lucky enough to have proper insurance and be admitted to the Mayo Clinic, the UCLA Medical Centre or Johns Hopkins, you will enjoy outstanding treatment. Unfortunately, as the tens of millions of uninsured and underinsured have discovered, America offers some of the most unreliable, costliest and least equitable health care in the world too.

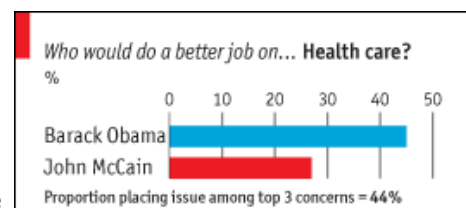
Two problems above all others have preoccupied those courageous enough to try to reform the \$2.5 trillion colossus that is America's health-care system. The first is expense. Costs in this sector have been soaring for decades, and in recent years have consistently climbed by 2.5 annual percentage points more than the growth rate for economic output. If these trends continue, the Congressional Budget Office estimates that Medicare and Medicaid (the government's health schemes for the elderly and the indigent) will soar to 20% of GDP by 2050—more than the entire federal budget.

The second big headache is coverage. Unlike other big industrialised countries, America does not have a health system (whether government run, as in Britain and Canada, or a public-private hybrid, as in Switzerland and France) that guarantees health cover to everyone. Around 46m Americans are uninsured, a figure that has risen from about 40m back in 1994.

This does not mean these unfortunates receive no health care at all, of course. If such people suddenly have an accident or a heart attack, they still turn up at hospitals, which are required by law to treat them. But such emergency care is often extremely expensive. Lack of insurance also discourages prudent investments in prevention.

So the uninsured problem ends by driving up overall costs too. That explains why reforming the system will require addressing both cost and coverage together. However, that is quite a mouthful to chew, and politicians have generally chosen one or the other to focus on as the first target for reform.

The Clinton administration first tried to promote universal coverage ("HillaryCare") and, when that failed, attempted to slash costs through the "managed care" movement, which was hated for restricting patients' choices. George Bush's modest attempts to control costs, by means of health savings accounts, have borne little fruit. And paradoxically, by bowing in 2006 to a demand from the elderly for subsidised prescription drugs at a cost of perhaps \$500 billion or more over ten years, he and the Republican Congress of the time almost certainly fuelled another round of nasty health-cost inflation.



Coverage or cost?

Given this history, it is understandable that Barack Obama and John McCain have put forward plans that, although more ambitious than Mr Bush's efforts, can hardly be called sweeping. Both candidates and their advisers insist piously that their particular proposals tackle both cost and coverage. Not so.

Look closely and it becomes clear that the two men have, in fact, made a clear choice to go after one of the two goals with more gusto: Mr Obama's plan focuses on coverage, while Mr McCain aims at cost. What is more, there is another clear distinction between the two candidates' plans. The Obama team acknowledges that his plan for coverage will be costly, and says he intends to pay for it in part from the government's coffers. In contrast, Mr McCain's advisers insist that his plan will be revenue-neutral over the long haul, and will therefore require no new government money.

In some ways, Mr Obama's decision to tackle the coverage issue is not surprising. In addition to the legions of uninsured, even those with corporate insurance now fear their firms will water down or scrap their coverage. Massachusetts has been pioneering reforms that promise universal coverage, and the pledge was a key plank in Hillary Clinton's failed primary campaign.

Mr Obama aims to expand coverage through a mix of new regulations, policy reforms and subsidies. Under his plan, insurers would no longer have the right to reject anyone as too ill or too costly. He would create a "National Health Insurance Marketplace" (akin to the regulated "connector" set up in Massachusetts) where individuals and firms could purchase either private insurance plans or public alternatives modelled on Medicare. In future all but the smallest of corporations would be required to offer insurance—or pay a stiff fine. Mr Obama would offer families tax credits for the purchase of either public or private insurance.

Will it work? Mrs Clinton insisted it would not. Her main objection was that this plan did not contain a key feature shared by her plan and the Massachusetts reforms: an individual mandate, or legal requirement, to purchase cover. Under Mr Obama's plan, the only personal mandate is that parents must buy insurance for their children. Fans of mandates argue that without compulsion, reform efforts will be upended by the problem of adverse selection. Young and healthy people opt not to buy coverage, leaving a sicker and so costlier risk pool.

Mr Obama's pragmatic, and politically clever, retort is that it is unreasonable to require individuals to purchase something whose cost cannot be known with certainty in advance. Therefore, he insists, he will take measures that will both expand the insurance market and reduce the overall cost of coverage by (he claims) some \$2,500 per typical family over time. That will make it so attractive to individuals to buy insurance, say his advisers, that 98% of people will do so.

Reforming the system will require addressing both cost and coverage together

This points to a few question-marks about Mr Obama's plan. One is that nobody knows how big the problem of adverse selection will be in a system without mandates. But supporting his argument for pragmatism is the trouble that Massachusetts is finding in implementing its ambitious mandate. Although hefty subsidies are provided for the poorest and insurers have been pressured to offer cheaper plans, far more residents than expected have found insurance unaffordable and have therefore been granted waivers. One architect of the state's plan says that unless costs are reined in rapidly, it "will fall apart in a couple of years".

The second unknown concerns how Mr Obama will pay for his plan, which his advisers reckon may cost \$50-65 billion a year. He says he will use the \$70 billion or so a year freed up by rolling back Mr Bush's income-tax cuts for the wealthiest, but critics complain that those tax cuts were supposed to expire soon anyway. If his promised cost savings do not materialise, the plan will become unsustainable.

As with Mr McCain's ideas on cost savings (below), it is hard to estimate how much money Mr Obama's policy fixes (such as boosting prevention) will save. Experts at the Tax Policy Centre (TPC), an independent think-tank based in Washington, DC, ignore such claimed savings completely in doing their sums. The TPC calculates the McCain plan will cost about \$1.3 trillion over ten years, while the Obama one will cost about \$1.6 trillion. Any cost savings will reduce those sums.

Penny-pinching

At the heart of Mr McCain's strategy is the elimination of the tax advantage enjoyed by employer-provided health insurance over the sort obtained by individuals directly with an insurer. This tax break has been a politically popular feature of America's corporate landscape since the second world war.

But most economists hate this giveaway, which costs the Treasury over \$200 billion a year, arguing that it distorts the market in two ways. It biases the market against individual plans, which receive no such tax

break. And it ties employees to firms, thus diminishing labour market flexibility.

Mr McCain's reforms would replace that corporate subsidy with a refundable tax credit, worth up to \$5,000 per family, for people to buy their own insurance from anyone they like. He would allow them to purchase insurance across state lines and through such organisations as churches. Unlike Mr Obama, he will not force insurers to accept everyone, but he will offer federal funding for state-run "high-risk pools" which (he claims) will defray the cost of covering the sickest.

Will it work? Mr McCain certainly deserves applause for proposing an end to the employer subsidy. That is worth doing, but it could make it less attractive for firms to offer health insurance. Mr McCain insists that very few big firms will actually drop coverage. But the boffins at the TPC are unconvinced. They calculate that Mr Obama's plan will reduce the number of uninsured quickly (by about 18m in 2009, and by 34m in 2018), but that Mr McCain's plan would lower the number by only 1m-5m by 2013.

Mr McCain's advisers reject that analysis, arguing that the tax credit given to individuals to buy insurance on their own will allow millions of Americans to get coverage, far offsetting any decline in corporate cover. But given that a typical health plan for a family costs \$12,000 or so, it is unclear how many of the working poor will be motivated by a \$5,000 refundable credit. The high-risk pools proposed by Mr McCain also raise doubts. States that have experimented with this timid approach to reform have mostly failed.

In the end, both plans have their virtues. With Mr Obama's, the big unknown is how much it will really cost to reach near-universal coverage, while the uncertainty about Mr McCain's strategy to tackle costs is whether it will do much to expand coverage. Given the growing ranks of the underinsured and an increasingly common view that this is a scandal for a country as rich as America—never mind the 46m with no health insurance at all—voters may prefer the plan that promises to cover everyone quickly, and let future voters worry about the cost.

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