

## Moral Health Care vs. “Universal Health Care”

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**Main Points:** *Surveys the history of government interference in health insurance and medicine in America, specifying the rights violations and economic problems caused thereby; enumerates the failed attempts to solve those economic problems by means of further government interference; and shows that the only viable solution to the debacle at hand is to gradually and systematically transition to a rights-respecting, fully free market in these industries. (This article can be accessed at the TOS website for free.)*

Although American scientists, doctors, and businessmen have produced the most advanced medical technology in the world, American health care is in a state of crisis. Technologically, we are surrounded by medical marvels: New “clot buster” drugs enable patients to survive heart attacks that once would have been fatal; new forms of “keyhole surgery” enable patients with appendicitis to be treated and discharged within twenty-four hours, whereas previously they would have spent a week in the hospital; advances in cancer treatment enabled bicyclist Lance Armstrong to beat a testicular cancer, which, had he lived fifty years ago, would have killed him; and so on.

From an economic perspective, however, such medical treatments are increasingly out of reach to many Americans. Health care costs, as reported by the *New York Times*, are rising twice as fast as inflation.(1) And health insurance, as reported by *USA Today*, “is becoming increasingly unaffordable for many employers and working people.”(2) A decreasing percentage of employers are offering health insurance benefits to their workers, and many of those who are offering benefits are requiring their employees to pay a greater percentage of the costs.(3) The U.S. Census Bureau reported in 2007 that nearly forty-seven million Americans had no health insurance, a sharp increase of ten million people from a mere fifteen years earlier.(4) In short, there is a major disconnect between existing life-saving medical technology and the ability of Americans to afford it.

This discord is affecting doctors as well. The American Medical Association warns physicians that, due to the lack of affordable health insurance, “more patients will delay treatment and . . . doctors will likely see more uncompensated care.”(5) Hence, each year doctors are working harder and harder but making less and less money, resulting in a “critical level” of stress and burnout. According to a recent survey of doctors, “30 to 40 percent of practicing physicians would not choose to enter the medical profession if they were deciding on a career again, and an even higher percentage would not encourage their children to pursue a medical career.”(6)

Total spending on health care in the United States amounts to nearly 17 percent of the entire economy, and this is expected to rise to 20 percent by 2015, “with annual spending consistently growing faster than the overall economy.”(7) Because of skyrocketing health care costs, the U.S. federal Medicare trust fund is expected to go bankrupt in 2019, less than twelve years from now, potentially leaving millions of elderly Americans without health insurance coverage.(8) American health care is in dire straits and will continue to worsen—unless Americans demand fundamental political change to reverse the trend. Unfortunately, the kinds of changes currently being proposed by politicians will only exacerbate the problem.

Politicians from across the political spectrum, including Democratic presidential candidate Hillary Clinton and Republican candidate Mitt Romney, have argued that the government should guarantee “universal coverage” to all Americans, making health care a “right.”(9) And politicians are not alone; numerous businessmen, union leaders, and insurance executives are united in saying that this will solve our problems.(10)

It will not.

Contrary to claims that government-imposed “universal health care” would solve America’s health care problems, it would in fact destroy American medicine and countless lives along with it. The goal of “universal health care” (a euphemism for socialized medicine) is both immoral and impractical; it violates the rights of businessmen, doctors, and patients to act on their own judgment—which, in turn, throttles their ability to produce, administer, or purchase the goods and services in question. To show this, we will first examine the nature and history of government involvement in health insurance and medicine. Then we will consider attempts in other countries and various U.S.

states to solve these problems through further government programs. Finally, we will show that the only viable long-term solution to the problems in question is to convert to a fully free market in health care and health insurance.

### **Government Involvement in Health Insurance**

Although health care and health insurance are often conflated, there is a crucial difference between the two. Whereas health care consists of the actual goods and services necessary for medical care, health insurance is one means of affording such care. The two are closely related but distinct, as are the services of an auto-body repair shop and an automobile insurance company.

Unlike those in more openly socialist countries who obtain health insurance directly from the government, Americans typically purchase health insurance from increasingly government-controlled insurance corporations, giving health insurance in America the veneer of a free-market industry. Behind the veneer, however, the industry is subject to countless state and federal laws, regulations, and taxes—which do not apply to all insurance companies equally.

In addition to taxing insurance companies on the premiums they collect, states typically require them to set aside monetary “reserves” to cover future claims. But some companies have been exempted from these taxes and requirements. During the Great Depression, hospitals and doctors organized their own insurance companies, known respectively as Blue Cross and Blue Shield (or “the Blues”). The Blues lobbied and convinced the states to treat them as nonprofit charity corporations rather than “for-profit” insurance companies, on the grounds that they were organized by doctors and hospitals. The Blues also requested and received tax-exempt status from the federal government. In return for their nonprofit status, the Blues agreed to offer health insurance on the basis of “community rating,” which meant that every customer would pay the same premium, regardless of age, sex, health history, lifestyle choices, or regional demographics.<sup>(11)</sup> (This was occasionally modified to reflect different premiums for age and location and was then called “modified community rating.”)

Commercial insurers—who were still required to pay taxes, establish reserves, and adhere to other state insurance regulations—had difficulty competing with the Blues, which, by the 1950s, together were the largest provider of health insurance in America.<sup>(12)</sup>

The primary goal of the Blues was to obtain steady income for their member doctors and hospitals by guaranteeing that they received payment for all the services they provided. Their strategy was to provide coverage for all expenses—even routine, ordinary, easily affordable medical services. In contrast to the original purpose of health insurance—which was to protect against rare, unforeseen, catastrophic expenses that could bankrupt a family—the Blues turned health insurance into a form of pre-paid medical care in which the insurance company (rather than patients) would pay doctors and hospitals for all medical services—catastrophic, routine, and everything in between—on a cost-plus basis. In an effort to compete with the Blues, more and more for-profit insurance companies offered similar plans, and the model of third-party insurance plans paying the providers directly with little or no input from the patient—and paying for routine care through insurance—became entrenched. This new model was a disaster in the making. In addition to minimizing incentives for insured customers to comparison shop for medical services, it also minimized incentives for doctors and hospitals to compete on price.<sup>(13)</sup>

The model created by the Blues and followed by commercial insurers was not the result of free-market thinking and competition. It was a direct result of government meddling and intervention, giving preferential treatment and economic advantages to one insurer (and its health plans) over others. This initial distortion of the health insurance market was exacerbated by the 1942 Stabilization Act, passed during World War II. This act froze wages nationwide but allowed employers to provide or increase employee benefits such as health insurance, since benefits were not considered wages under the Act. In 1943, in response to the Act, the IRS decreed that health insurance premiums paid by employers are not taxable income to employees and are therefore exempt from federal income tax. The IRS further decreed that health insurance premiums are a legitimate cost of doing business and can be deducted from the employer’s taxable income.<sup>(14)</sup> These decrees were later codified into the Internal Revenue Code of 1954.

These income tax laws are largely responsible for the explosive growth in employer-purchased health insurance. In 1939, only 6 percent of the population had health insurance of any kind, and only a small fraction of those insured had employer-sponsored health insurance.<sup>(15)</sup> By 1960, 18 percent of the population was insured under an employer

group plan, and that percentage grew to almost 70 percent of the insured by 1980.(16) The percentage has since declined, but even today about 60 percent of insured Americans obtain health insurance through their employer.(17)

This preferential government treatment of Blue Cross and Blue Shield over other insurance plans, combined with the tax breaks to recipients of employer-sponsored health insurance plans, has wreaked havoc in the American health insurance industry in myriad ways.

When employers pay for health insurance, employees tend to remain largely unaware of the costs involved. And even if they are aware of the costs, because the insurance is paid for with pretax dollars, employees cannot as easily compare its value to that of other benefits such as vacation time, personal days, or retirement savings. Further, because employer-paid health insurance premiums are not taxed as income, many employees come to think of them as a normal condition or an entitlement of employment and feel shortchanged when the employer tries to shift part of the cost to them.

Because employees do not own their plans, and because the employer is insuring a group without regard to any one individual's condition, individuals with employer-purchased policies have little or no say about the policy under which they will be insured. As the Joint Economic Committee of the U.S. Senate reports, nearly four out of ten workers with employer coverage have no choice of health plans, and less than half have a choice of more than two plans.(18)

Having not been in charge of evaluating, comparing, or selecting their health insurance plans—having paid little or no attention to the various costs involved or the types of benefits offered—many employees, when given a choice, opt for “smaller” out-of-pocket costs and “greater” benefits, and grumble when the former increase or the latter decrease.

Whereas people generally keep the same auto or homeowners insurance for many years, employees rarely have the same health insurance for more than two or three years, even while remaining with the same employer, because the employer chooses and changes the plans at his discretion, usually with an eye toward minimizing premium costs. Unlike auto insurance policies, under which the insurers often give significant discounts to safe owner-drivers in order to retain them as long-term customers, under employer-sponsored health insurance, the employers, not the employees, are the customers, and there is little, if any, financial incentive for insurers to build long-term relationships with the employees.

Another drawback to employer-paid insurance policies is that they make it difficult for employees to keep sensitive health issues from employers. Many large employers are self-insured, which means that the employer sets aside money it would have paid as insurance premiums, and, instead, directly pays the claims of its employees (and their families). Generally, the employer buys a catastrophic policy or a reinsurance policy for losses in excess of a huge deductible. In those cases, the employer/insurer is very much aware of every dollar that is spent for any claims, and, because it is paying the bills, may even have access to all of an employee's (or his family's) medical information.

Additionally, the tax waiver for employer-paid health insurance has tied workers to their employers in a damaging way. Many workers with preexisting conditions or serious chronic illnesses—or who have spouses or children with such conditions and illnesses—stay in less than desirable jobs solely to avoid the risk of changing or losing their health insurance. Currently, one out of seven Americans says he needs to remain in his current job rather than take a new job in order to keep his health insurance benefits.(19)

Employer-paid insurance has also been hard on employers. As health insurance costs have risen faster than other costs, premium increases amount to an increase in wage costs disproportionate to revenue increases and independent of employee productivity. This is the reason that many employers are cutting back the amount of money they spend on health insurance, trimming benefit packages, increasing employee co-pays, and requiring employees to pay a larger portion of the actual insurance cost.

Further, as indicated earlier, employer-sponsored insurance treats a large minority of the population unfairly through unequal tax laws. Whereas employees with an employer-paid health plan get their benefits tax-free, individuals who purchase health insurance on their own do so with after-tax dollars. Consequently, a person buying an individual policy may pay up to 30 percent more (depending on his tax bracket) for the same policy benefits.

Given the existing tax burden on Americans and their justified efforts to legally shield their money from tax collectors, the tax-exempt nature of employee-paid health insurance further raises the costs of health insurance. To understand this, consider that homeowners generally pay for their own house maintenance such as lawn work, painting, and remodeling. Routine maintenance is not covered by homeowners insurance; only damages resulting from a tornado, fire, vandals, or some other catastrophic event are covered. But suppose the government suddenly decreed that it would exempt from income taxes any money spent on homeowners insurance. This would reduce taxes for insurance-paid repairs. Accordingly, people would seek insurance policies that cover routine home maintenance, such as painting, carpet replacement, and fence and deck maintenance—and insurers would provide them. Although these new policies would cost more, they would seem on the surface to be a bargain because homeowners would be spending untaxed dollars. Demand for home repairs would skyrocket. More money would be spent on home maintenance, and the cost of home insurance would quickly outpace that of other goods and services. To remain in business, home insurers would limit coverage for more expensive repairs. Simultaneously, to curry favor with their constituents, politicians would seek mandates to expand coverage, and, of course, they would demand further regulations to make sure that poor homeowners had “access” to homeowners insurance. This is precisely what has happened with health insurance.

Just as spending money in that way would make economic sense under that tax law, so using employer-sponsored health insurance to pay for small claims makes sense under the current tax laws. David Henderson, who served on President Reagan’s Council of Economic Advisers as a senior economist for health care policy, observes:

The employee is better off to charge a \$50 doctor bill to the insurance company—even if the [insurance] company spends \$20 to process it—and have the employer pay the extra \$70 in a higher premium to cover the bill and the processing cost. The alternative—having the employer pay [the employee] an extra \$70 in cash—yields the employee only about \$42 [because of federal income, social security, and Medicare taxes] and costs the employer \$75.36 (\$70 + \$5.36, the employer’s portion of the social security and Medicare tax on \$70).(20)

The current system of employer-sponsored health insurance is a catastrophe, and it is a result of government intervention in the free market. Such intervention violates the rights of insurance companies, employers, and consumers by granting special government favors to certain insurance companies or plans, by forcibly eliminating options that would exist in a free market, and by forcibly seizing money from insurers and the insured. It artificially places employers and insurers between doctors and patients and leads to innumerable economic distortions. Employers and insurers dictate everything from which doctors and specialists employees will be permitted to visit under the plan, to the kinds of benefits that will and will not be provided, to the co-payments and deductibles that will be paid. Because third parties are paying for both insurance and health care, the employee-patient-customer has little choice in what kind of insurance or who provides the health care he receives—and plenty of incentive to visit a doctor anytime he has a runny nose. The fact that third parties pay for all health care increases the administrative costs for doctors as well as insurers, and those costs are passed on to consumers.

These problems were further exacerbated in the mid-1960s with the creation of two federal insurance programs: Medicare (for the aged) and Medicaid (for the poor). Both had major effects on the private insurance market. When Medicare was proposed, advocates claimed that it would not interfere with the doctor-patient relationship or patient choice—it would merely pay the bills. In fact, however, it has drastically changed the doctor-patient relationship and sharply limited patient choice. Medicare determines what procedures and treatments are “appropriate” and “medically necessary.” It also determines the monetary “value” of a diagnosis, treatment, or procedure. Both patient and doctor must abide by Medicare’s decision; and, despite low Medicare reimbursements, doctors cannot accept any money from a patient beyond what Medicare pays, even if the patient so desires.(21)

Doctors are paid so poorly by Medicare and burdened by so much paperwork that about 28 percent are turning away some or all new Medicare patients.(22) Hence, newer Medicare patients often cannot find a doctor in their area who will treat them at all. Such “insurance” does these patients no good. Nor do they have any private insurance alternative. With the insignificant exception of Medigap policies, Medicare has eliminated the private insurance market for the elderly, and many elderly patients are left with no way to seek medical treatment except through hospital emergency rooms or charity. (A person who purchases a private policy prior to turning sixty-five may be able to retain it after turning sixty-five, but such a policy will then only supplement Medicare.)

Medicaid is a bigger problem. Medicaid reimbursement rates for doctors and other providers are generally even lower than they are for Medicare, and many doctors opt out of treating Medicaid patients. Only about 52 percent of doctors accept new Medicaid patients, whereas 99 percent will accept new private insurance patients.<sup>(23)</sup> Moreover, many doctors who do take Medicaid patients limit the number of Medicaid patients they see each week so that they can control their income loss. It is not unusual for a Medicaid patient to have no family doctor because he cannot find a nearby doctor who will treat him, a problem that is especially severe in rural areas. As a result, for years Medicaid patients have used emergency rooms as their regular source of treatment: Emergency rooms charge no co-pay or deductible; they perform tests right away; they generally provide high-quality health care; and they cannot refuse patients. (We will elaborate on this last point later.)

In financial terms, Medicare and Medicaid are bankrupting our state and federal governments. These two federal insurance programs compose nearly 20 percent of the federal budget, and the percentage keeps rising. In addition, for most states Medicaid is the largest single budget item, averaging 22 percent of states' spending. Medicaid is generally administered by the state, with matching federal tax dollars. As a result, states seek to expand Medicaid coverage and other medical programs such as SCHIP (State Children's Health Insurance Program) in order to reap more of the matching federal dollars. Eligibility for these programs continues to expand, and, in some states, families with incomes as high as \$55,000 are now eligible for Medicaid benefits. Federal, state, and local governments now pay 50 percent of every dollar spent on health care, even though government health insurance covers only 27 percent of the population.<sup>(24)</sup>

By tying health insurance to employment through the income tax law—by providing preferential legal status and tax treatment to nonprofit companies and their payment plans for routine services—and by establishing government health insurance for the aged and the poor in the form of Medicare and Medicaid, the government has created a system that violates individual rights and fosters an entitlement mentality. Consequently, while more and more of their rights are being violated, more and more Americans are coming to expect health insurance to cover everything—from routine care to catastrophic care to screening exams to diagnosis to treatment for chronic conditions to rehabilitation—for everyone, without any limitations, and at very little out-of-pocket cost to those “covered.” To grasp the absurdity of this, imagine the government applying the same kind and degree of force against producers of other life-or-death commodities, such as food, clothing, and shelter. Then again, no imagination is necessary, because that is precisely what the Soviet Union did.

Governments have further interfered with the free market by means of health care mandates—governmental decrees regarding how health care providers and patients can or must act. There are essentially four kinds of mandates, and they are applied to three different markets in health insurance: the large group market (generally more than fifty members), the small group market (generally one or two to fifty members), and individual market (single individuals or a family). Let us take a look at each of these mandates.

“Benefit mandates” dictate (1) the range of benefits—such as the kind of treatments and procedures and diagnostic tests—that insurance companies must provide, (2) the type of health care providers that may be included under a given policy, and (3) who must be covered under the policy. For example, some states mandate that all individual health insurance policies include alcohol rehabilitation benefits (a kind of treatment) or naturopathic benefits (a type of provider)—even for customers who do not want and will never use those benefits. Customers cannot contract for just the benefits they want, and insurers must price policies with the expectation that policyholders might use any covered service.

There are as many as 1,900 separate mandates across the country, and more than half the states have 35 or more mandates, with Idaho having the fewest at 14 and Maryland having the most at 62.<sup>(25)</sup> These mandates violate the rights of insurers and customers to choose their own policies and coverage. They limit an insurance company's ability to offer inexpensive and reduced benefit packages for the young and healthy, or to tailor policies to a person's needs or wants, or to offer low-cost, high-deductible policies that cover only catastrophic events. They force unwanted coverage upon customers, raise the costs of each insurance policy involved, and retard innovation in the marketplace.

Benefit mandates also serve as a giant magnet for special interest groups. Groups of people who suffer from a particular condition have lobbied successfully to force insurers to cover their condition. For instance, in various states special interests have successfully campaigned for coverage of autism diagnosis and treatment, cervical cancer

vaccine, mental health benefits, alcoholism treatments, and morbid obesity treatments. They have required insurance companies to provide coverage for “children” up to age thirty. Other special interests include vendors such as massage therapists, pastoral counselors, and athletic trainers who have lobbied successfully for their services to be covered by health insurance.

Although insurance companies should be free to offer such coverage, no one—including the government—has a right to force them to do so. This is the health care equivalent of the government requiring all homeowners insurance policies to cover theft of coin collections, even though most homeowners do not own coin collections.

Benefit mandates violate the rights of insurers and the insured, and they increase the cost of health insurance policies. But they are not the most onerous of the mandates.

“Mandatory guaranteed issue” requires that an insurance company in a given market grant a policy to anyone who applies. Federal law requires that small-group policies be guaranteed issue.<sup>(26)</sup> In this market, it requires that an insurer accept any group that applies for insurance and everyone in that group, regardless of their health condition or lifestyle choice. For example, under guaranteed issue, a health insurer accepting an employer group must accept a motorcyclist employee who has had several serious injuries from multiple accidents due to reckless riding. Likewise, another employee who is fifty pounds overweight, smokes three packs of cigarettes a day, and has high blood pressure, diabetes, and a heart condition cannot be refused. Since insurers cannot exclude anyone who already suffers from serious health problems or who chooses to risk his health with poor lifestyle choices, they must price their policies accordingly.

When fully voluntary, guaranteed issue is not necessarily a bad option, and many health insurance companies offer such voluntary policies. But these plans limit coverage (e.g., a policy might limit hospital coverage to \$1,000 per day) and charge higher premiums for the policies, because most people seeking them have serious health problems and are not economically insurable otherwise. But when government violates individual rights by requiring mandatory issue, insurance companies are forced to choose between two economically unacceptable alternatives: (1) raising everyone’s premiums, which will, in turn, cause the less affluent individuals or employers to forgo insurance; or (2) ceasing to do business in that market.

Several states, including Kentucky, Maine, and Washington, have introduced mandatory guaranteed issue into their individual insurance markets. After Kentucky introduced the mandate, forty-five of fifty insurers withdrew from the market there, which, in turn, led to fewer options and higher costs for consumers. In 2000, Kentucky eliminated the mandate, hoping to recapture the competition and choice offered by its lost insurance market, and since then several of the insurers have returned. Maine is now down to two insurance companies, and rates have increased 124 percent in six years. The state of Washington has seen the number of insurers decline from thirty to seven while costs have increased.<sup>(27)</sup>

All of this follows logically from the nature of mandatory guaranteed issue. Forcing insurers to accept all applicants means that they must either increase their rates to pay for sicker customers who will certainly want the insurance and have many claims—or leave that state’s market and go where they can earn a profit.

The same logic applies to “guaranteed renewability mandates,” which require that an insurance company renew a policy automatically as long as the premiums are paid. Guaranteed renewability is part of the federal law on small-group policies, and many states apply it to individual policies as well. Again, when an insurance company cannot refuse high-risk consumers, it has to charge higher premiums or drop out of the market.

Another common government mandate is “guaranteed community rating.” This means that all persons in a given community must be charged the same premium. Recall that the Blues agreed to offer community rating in exchange for nonprofit charity status when the companies were first formed. Mandatory community rating prohibits insurance companies from considering a person’s health history or present condition, or even his height and weight as a factor in issuing the policy. One consequence is that the young and healthy—those eighteen to thirty-five years of age with no medical problems—will pay the exact same premium as a sixty-year-old person with several chronic health conditions. This prevents insurers from offering lower rates to those who act to preserve and protect their health.

Some community rating is “modified,” which means that it allows insurers to account for one or two relevant rating factors, for example, age and location. Although this is a tad less coercive, it is still coercive; it still thwarts the judgment and harms the lives of insurers and healthy consumers. For instance, all healthy consumers in a given age group who do not submit any claims are forced to pay the same premiums as those who are sick and who submit many claims. Further, if an insurer must charge the healthy the same rate as the sick, then there is no financial incentive for either not to use the policy as much as possible, for every ache or pain, no matter how trifling. This results in increased administrative costs for doctors and insurers, who have to process these petty claims.

More significantly, however, states that have either guaranteed issue or some form of community rating tend to have both. With both mandates in place, those who are healthy tend to wait until they get sick to buy insurance. There is no need to buy insurance while you are healthy if insurance companies charge the same for sick or healthy customers and if they are required to accept you as a paying customer whenever you apply. These mandates quash the very purpose of insurance, which is to spread risk among the healthy; their effect is to spread health expenses among the sick and the less sick. This, in turn, requires insurers to raise their rates or, if states prohibit higher prices, to leave those states.

When combined, these guaranteed issue, guaranteed renewability, and community rating mandates eliminate the financial consequences to individuals related to their lifestyle choices, for good or ill. Consumer-patients have no financial incentives to get regular screening exams, to eat a healthy diet, to exercise regularly, or to avoid unhealthy or dangerous activities. Consequently, those who voluntarily choose healthy lifestyles are forced to subsidize the higher health care costs of those who do not.

One “argument” for these particular mandates is that without them, insurance companies would refuse to sell policies to people with serious or chronic health conditions, and thus either “society” would have to pick up the slack in the form of public programs or doctors and hospitals would have to pick it up in the form of uncompensated care. But it is not true that in a free market no insurance would be available for people with serious or chronic health conditions. As indicated earlier, even in today’s coercive environment people who are otherwise “uninsurable” can buy policies with limited benefits. And in a free market, insurers would be free to offer policies to high-risk individuals, or to those with preexisting conditions, at prices that make economic sense for everyone involved.

Most states have a combination of these four mandates, which increase the cost of policies from 20 to 40 percent. In 2006, the Colorado Commission on Mandated Health Benefits reported research concluding that every 1 percent increase in premium causes three to four thousand people in Colorado to discontinue their insurance; nationally, that same 1 percent increase results in two hundred thousand families dropping their insurance.(28) Other research indicates that 20 to 25 percent of the uninsured are uninsured because of the high costs caused by mandates.(29) Mandates prevent millions of Americans who want to buy insurance from being able to afford it.

In addition to the aforementioned mandates, two particularly monstrous new ones are now being discussed and, to some extent, implemented. “Individual mandates” and “employer mandates” would require every person, or every employer on behalf of every employee, to purchase health insurance—regardless of an individual’s or company’s financial ability, regardless of a recipient’s age or health, regardless of a company’s size—regardless of any logically relevant factors. Presidential candidates Hillary Clinton, Chris Dodd, and John Edwards have proposed individual mandates as part of their platforms for health care “reform.”(30) And Massachusetts just instituted both individual and employer mandates, although it later had to weaken those mandates because the state was unable to afford the expensive subsidies for those who could not afford the mandated health insurance themselves.(31)

Contrary to widespread confusion, the high prices and lack of choices in today’s health insurance industry were not caused by a free market; they were caused by government interference in the market. Given the regulations imposed on employers, insurers, consumers, and taxpayers, the market has done remarkably well. Despite all the government interference, about 50 percent of Americans still have private insurance, and about 10 percent of the insured purchase individual policies.(32) But seventy years of government interference in health insurance has caused tremendous harm, and that interference grows worse each year.

Government intervention has violated the rights of providers and consumers to contract as they see fit, violated the rights of insurers to offer products of their choice in the marketplace, violated the rights of consumers to purchase insurance according to their best judgment, and created uneven tax burdens that are detrimental to individuals

without employer-sponsored insurance. It has also caused consumer-patients to stay at less desirable jobs in order to keep their health insurance, left them vulnerable to their employer's or the government's cost-centered health insurance plan, nullified the judgment of health care professionals in the diagnosis and treatment of patients, and left some consumers with health insurance policies but without access to health care.

Bearing in mind what government intervention has done to health insurance, let us turn to its effect on medicine.

### **Government Intervention in Medicine**

As with health insurance, government has meddled in the market for medical products and services for decades. Government routinely violates the rights of doctors and other allied professionals by forcing them to act against their best judgment; it regulates the licensing and practices of professionals and facilities; it forces doctors and hospitals to offer services without compensation; it subjects doctors to fines and jail terms for errors in the documentation of patient records and claims; consequently, it stifles productivity, hampers quality, increases the cost of medical goods and services, and causes unnecessary suffering and death. In support of these claims, let us look first at the laws regarding emergency room treatment and medical record keeping.

Today's emergency rooms (ERs) are frequently overcrowded; visitors can find themselves waiting hours for medical care that they need immediately. Much of this overcrowding is due to Medicaid and Medicare patients who do not need emergency medical care but who use the ER because their socialistic insurance makes it the best and cheapest place to get routine care. Medicaid patients are four times more likely to seek treatment from an ER than are those with private insurance.(33)

In addition to the overcrowding of ERs caused by Medicaid and Medicare, more than half of today's hospitals report losing money on emergency care for those covered by these policies, because neither program fully covers the costs of treatment.(34) Although approximately 14 percent of ER users are uninsured, the larger Medicaid-Medicare population causes the lion's share of the problem. A recent study demonstrated that frequent users of ERs tend to be young, female, homeless (or marginally housed), and Medicaid- or Medicare-insured (as opposed to uninsured).(35)

One reason for the overcrowding and overuse of ERs is the Emergency Medical Treatment and Labor Act of 1985 (EMTALA).(36) This law requires that hospitals that accept Medicare patients diagnose and treat anyone who comes within two hundred feet of an emergency room, regardless of whether the person can pay for the treatment. The effect of this law is that anyone can walk into an emergency room at any time and receive treatment—without concern for payment. If a bum wants a free meal and a warm bed for the night, all he has to do is walk into the ER and say, "Doc—I feel like an elephant is sitting on my chest!" By law, the emergency room doctor and staff have to run tests until they can prove that he is not having a massive heart attack and can be safely discharged. And the failure of a hospital or physician to comply with any EMTALA-mandated responsibilities can result in fines of up to \$50,000 for each infraction.

Because of the low reimbursement rates paid by Medicaid and Medicare, many recipients have no regular primary care physician and can get decent care only through the ER. Medicaid compounds this problem by not requiring patients to pay *any* deductibles or co-pays for emergency room visits.

EMTALA enslaves doctors. They are required to treat patients who are not required to pay them. What other industry is required by law and under penalty of a fine to provide services on a regular basis without any promise of payment? How long could restaurants survive if a law required them to serve free meals to anyone who showed up at the door and said he was hungry? How many grocery stores could exist if they were required to allow people to walk out with food that had not been paid for? EMTALA is classic socialist doctrine applied to medicine: Each patient gets care according to his need from each doctor according to his ability.

EMTALA not only enslaves emergency medicine physicians; it also enslaves any specialist called to the ER to treat a patient. For instance, because hospitals are required to treat patients at the ER, a hospital will typically require a cardiologist who admits one of his own patients to the hospital's cardiac care unit to also be on call to take care of any ER patient who presents with a cardiology problem.

Not surprisingly, as a result of EMTALA, hospitals are closing emergency rooms. According to the American College of Emergency Physicians, from 1993 to 2003, while the U.S. population grew by 12 percent, emergency room visits grew by 27 percent—from 90 million to 114 million visits. In that same period, however, 425 emergency rooms closed (14 percent of the ERs that existed in 1993), along with 703 hospitals and nearly 200,000 beds.(37) More close every year.

By mandating that doctors and hospitals treat patients at a financial loss, EMTALA violates the rights of doctors and hospitals to set the terms of their business. Consequently, doctors who are unwilling to lose money or who are tired of treating dishonest patients withdraw from emergency rooms. This leads to more overcrowding, longer waiting times, and, in some cases, the closing of ERs. As the remaining ERs become still more overcrowded and understaffed, the quality of emergency room services necessarily declines, harming honest patients who have genuine emergencies.

EMTALA also causes cost-shifting, the practice of doctors and hospitals trying to make up for the money they are losing on Medicaid and Medicare patients by increasing the fees of patients who have private insurance or who do not have insurance but do pay their bills. This raises the costs for responsible and conscientious patients, who indirectly subsidize the irresponsible and the unconscientious.

Another government-mandated problem for doctors and hospitals is the Health Insurance Portability and Accountability Act (HIPAA). Most people know of this act because of the paperwork everyone must now sign when visiting a doctor's office. Patients must acknowledge in writing their right to medical privacy. Although this is just one more piece of paper for a patient, it is hundreds more for each doctor, and thousands for each large clinic or hospital. And HIPAA's bureaucratic regulations do not merely mean more paperwork.

A particularly onerous aspect of this coercion is that doctors are subject to civil and criminal penalties for privacy errors in record keeping. The federal Department of Health and Human Services (HHS) may impose civil penalties of \$100 per failure to comply with a privacy rule requirement, up to a maximum of \$25,000 per calendar year for multiple violations. This means that a doctor may be subject to a fine if he forgets to ask a patient to sign the HIPAA form, even if neither the doctor nor his staff improperly releases any of that patient's private information. And a doctor who knowingly obtains or discloses individually identifiable health information in violation of HIPAA faces a fine of \$50,000 and up to one-year imprisonment.

An emergency room physician told one of the authors of this article that he and his colleagues have to violate the criminal provisions of HIPAA every day because, in order to save lives in an emergency situation, ER physicians must routinely treat patients and release information to their immediate family members without following the HIPAA documentation rules. It would be immoral for ER doctors to strictly comply with the law, as it would delay emergency medical treatment, keep families from understanding their loved-one's condition, and preclude the crucial sharing of knowledge between family members and doctors about the history and condition of the patient. This law (and others like it) turns doctors into criminals, not for providing substandard medical treatment, but for failing to put government paperwork ahead of the lives of their patients. Fortunately, most ER doctors are still willing to put their patients' lives ahead of paperwork, even when it means violating federal law.

But, in typically bureaucratic fashion, federal law does allow a doctor to pay a smaller fine for HIPAA violations if he can show that he established procedures and a compliance program specifying how he intends to comply with the HIPAA laws. In other words, if a doctor spends time and energy proving that he has procedures to comply with the HIPAA laws, but does not comply, he may be fined less than he would if he had no written HIPAA procedures in place.

A compliance program must include several strictly-enforced elements, such as a set of written standards and procedures for privacy issues, a designated compliance oversight officer, privacy compliance training, and so forth. These requirements apply to all medical staffs—from small one-doctor offices to large university hospitals. This imposes a significant financial burden on an individual or small family practice that might otherwise barely break even. (Medicare and Medicaid also impose complicated requirements for filing claims and proper coding, with penalties or even jail time for failing to fill out paperwork properly.) In other words, HIPAA is not about patient safety, patient care, medical training, medical standards, or anything having to do with the quality of medical care that a patient may receive. The sole purpose of HIPAA is to force doctors to document the patient's recognition of

his right to keep his medical records private—a right that doctors and patients have acknowledged and respected for years—and a right that they would, of economic necessity, acknowledge and respect in a free market.

It is no wonder that some doctors have stopped accepting both government insurance and private insurance. Currently, only a small fraction of doctors choose this course, but for them the regulations involved in insurance claims now make noninsured patients the most desirable, because they pay cash and entail no bureaucratic hassles.(38)

EMTALA and HIPAA are not the only regulations imposed by government on doctors and hospitals, but they should suffice to make our point. Regulations on medical care violate the rights of doctors and hospitals to determine which patients they will treat, in what manner, and for what fee; they also cost doctors and hospitals an enormous amount of money—by one estimate, at least \$169 billion a year. Coercive regulations in both medicine and health insurance violate the rights of doctors, hospitals, businessmen, and patients—and decrease the quality of care while raising its cost.(39)

Let us turn to some of the attempted solutions to this problem.

### **Attempted Solutions**

As we consider the following attempted solutions, observe that in each case health care is treated as an entitlement rather than a commodity, and that health insurance (or “coverage”) is conflated with health care. We will look first at attempted solutions in Canada; then we will turn to similar efforts in Tennessee, Hawaii, and Massachusetts.

In Canada, the government health care system evolved over several decades, starting in 1947 and culminating in the 1984 Canadian Health Act. The goal of the system was and is to provide “universal guaranteed” access to medically necessary health care services for all Canadians. This is a “single payer” system, which means that (with rare exception) the government, rather than patients or insurance companies, pays for everyone’s essential medical services. Doctors and hospitals provide medically necessary care to patients, and the government pays the bills. Further, doctors cannot charge patients separately for the services they provide; they can only accept the fees paid by the government. In leftist theory, all medical care is “free”; everyone has equal “access” to it; and no one is denied health care because he is unable to pay. In practice, however, this theory proves wanting.

In Canada, each citizen is forced to pay for his neighbors’ medical care in the form of taxes that are higher than he would otherwise pay. The Canadian health care system consumes nearly a quarter of total federal, provincial, and local tax revenues, which is more than in any other Western country except Iceland.(40)

In the name of “equal access” to health care, doctors (with rare exception) are forbidden to provide essential care to patients outside of the system, and citizens are forbidden to spend their own money on medically necessary care for themselves or their loved ones. Doctors are penalized for accepting money from patients for medical services that are covered by the government system. Private spending for state-covered medical care is illegal; everyone is forced to wait his turn on the government waiting list or “queue.”

There are waiting lists for MRI scans, heart surgery, chemotherapy, and every other essential medical service. The government uses these waiting lists to control costs. For instance, to avoid paying too much for heart surgery, the government limits the number of surgeries it will pay for each year. This imposes another cost on patients, one in addition to the money they have already paid in higher taxes: the cost of their *time*.

According to the Vancouver-based Fraser Institute, “Canadian doctors say patients wait almost twice as long for treatment than is clinically reasonable, . . . almost 18 weeks between the time they see their family physician and the time they receive treatment from a specialist.”(41) Consequently, mortality rates for treatable conditions such as breast cancer and prostate cancer are substantially higher in Canada than in the United States.(42) A Canadian woman who discovers a lump in her breast might wait several months before she receives the surgery and chemotherapy she needs, with the cancer cells multiplying rapidly all the while.(43) If she lived in the (as yet) less-socialized United States, she could receive treatment within days.

Canadian waiting lists routinely deprive patients of crucial, irreplaceable time, and this burden falls hardest on the sickest patients, those with the least time to spare. In some cases, it can cost them their very lives. Canadian patients routinely suffer and die while waiting for their “free” health care. The National Center for Policy Analysis notes: “During one 12-month period in Ontario, . . . 71 patients died waiting for coronary bypass surgery while 121 patients were removed from the list because they had become too sick to undergo surgery.”(44)

Of course, certain Canadians can and do attain preferential placement on the lists; politicians and celebrities use their pull to move up the waiting lists—something that ordinary Canadians bitterly refer to as “queue jumping.” And wealthy Canadians can avoid the waiting lists altogether—by traveling to the United States to purchase the care they need.

On the patient side of the equation, the people most harmed by the single-payer system are average Canadians and “the poor.” On the doctor side of the equation, we find further problems.

In 2003, then-president of the Canadian Medical Association, Dr. Sunil Patel, reported: “Physicians across Canada are in an advanced stage of burnout due to work conditions. . . . That burnout causes them to retire early or pull away from certain kinds of work or simply leave.” According to the *New York Times*, specialists have been leaving Canada to practice in the United States because of deep unhappiness with “Canada’s health care system, which is driven by government-financed insurance for all . . . [and which] increasingly rations service because of various technological and personnel shortages.”(45) According to the Canadian Institute for Health Information, in just six years, between 1996 and 2002, this “brain drain” amounted to “a net migration of forty-nine neurosurgeons from Canada . . . a large loss given that there are only two hundred forty-one neurosurgeons in the country.” “It’s not about the money,” says neurosurgeon Dr. Siva Sriharan; “[rather, it’s that] we can’t do our job properly with operating room time so extremely limited here.”(46)

The flight of doctors from Canada to the United States has become a serious problem for Canadians. A recent study by the Canadian Medical Association (CMA) reports that one in nine doctors trained in Canada now practices in the United States: “[T]his is equivalent to having 2 average-sized Canadian medical schools dedicated to producing physicians for the United States”—and there are only seventeen medical schools in Canada.(47) This exodus of Canadian physicians involves not only primary care physicians but also specialists, who can make two to three times more money in the United States than in Canada.

Walter Rosser, M.D., head of the department of family medicine at Queen’s University in Kingston, Ontario (and one of the coauthors of the CMA study), correctly blames the loss of primary care doctors on Canadian government policy.

[T]he majority of Canadian-trained family physicians in the United States left Canada because they were dissatisfied with the policies of the Canadian government. In the late 1990s, the country’s Ministry of Health and Long-Term Care said it was going to make all new medical graduates practice in underserved areas, a pronouncement that convinced a lot of family physicians to leave Canada for the United States. . . .(48)

When the only reward that Canadian doctors can look forward to after many long, hard years of study and training is a job in a government system that dictates where they can live, how they must practice, and how much they can earn, it is no surprise that many of them refuse to work in Canada.

The Fraser Institute summarizes the key differences between Canadian and American health care as follows:

Health care appears to cost less in Canada than in the United States largely because Canadian public health insurance does not cover many advanced medical treatments and technologies that are commonly available to Americans. Canadian patients do not get the same quality or quantity of care as American patients. On a comparable basis, Canadians have fewer doctors, less high-tech equipment, older hospitals, and get fewer advanced medicines than Americans.(49)

These differences are a direct result of the fact that Canada is a worse violator of the rights of doctors and patients than is the United States. To guarantee Canadians “free” health care, the Canadian government forces individuals to pay for their neighbors’ medical care and limits their freedom to pay voluntarily for their own. With bureaucrats deciding who receives what, individuals are forbidden to spend their money according to their own judgment (and the advice of their doctors) as to what is best for their health. Since an individual’s own judgment is his basic means

of living, when the government forces individuals to act against that judgment, unnecessary suffering and death naturally follow.

These problems are not unique to Canada. Similar problems abound in other countries, such as Sweden and the United Kingdom, that have adopted their own versions of government-run “universal health care.” And not only are the problems similar; the means by which the problems arise are similar. In each case, on the grounds that people have a “right” to health care (or cheaper health care), the government violates the rights of businessmen, doctors, and patients by interfering with the free market, which results in rising costs. Then the government further violates individual rights, via rationing, in order to control the increasing costs caused by its earlier rights violations. And so on. All the while, the commodity that is health care becomes more expensive and less available for everyone.

In Sweden, when the prime minister decided to go through the national system for his hip replacement surgery, he suffered for eight months in great pain, affecting both his ability to work and his ability to enjoy life. This kind of waiting and suffering is typical for Swedes in need of medical care—including heart surgery.(50)

In the UK, government intervention has led to such a shortage of health care that the British Medical Association has explicitly acknowledged that health care must be rationed: “British doctors will take the historic step of admitting for the first time that many health treatments will be rationed in the future because the NHS [the government-run National Health Service] cannot cope with spiraling demand from patients.”(51) Such rationing is the inevitable outcome of a government-run health system.(52)

Observe that all of these allegedly ideal systems guarantee health “coverage,” but they do not and cannot guarantee actual medical care. Health “coverage” (or health insurance) and health care are not the same thing, and, as economist David Hogberg explains, the distinction between the two is of crucial importance:

Believing health care and health insurance are the same thing easily leads to some mistaken, if not dangerous, notions. It leads to the beliefs that (1) universal health care and universal health insurance are the same; and (2) that if a nation has universal health insurance, where the government pays for every citizen’s health care, that nation will have universal health care, where citizens will have ready access to health care whenever they need it. As the experience of other nations shows, however, universal health insurance often leads to very restricted access to health care.(53)

Failing to recognize this distinction, various U.S. states have attempted to guarantee “universal coverage” for their residents. Although their specific methods of implementation have differed, they have all run into similar problems.

In the 1990s, Tennessee attempted to provide universal coverage by expanding the state Medicaid program to include people earning up to 300 percent of the federal poverty line (i.e., a middle-class family of four making about \$55,000 a year). This new program was called TennCare. The state also forced insurance companies to offer expensive additional benefits and forced employers either to buy health insurance for their employees or to pay into a state fund for the uninsured. Many employers chose the second option, shifting their employees’ health costs onto taxpayers. Because of these regulations, many insurance companies withdrew from Tennessee, and, consequently, more people fell into the state’s “health” plan.(54)

Predictably, costs rose (in part) because patients had no incentives to spend prudently. In response, the government attempted to control costs by slashing payments to doctors and hospitals. Hospitals closed, and doctors left the state. Many doctors who remained stopped seeing TennCare patients, because they lost money on each one.(55) Families with sick children often had to drive long distances to find a doctor who would see them. They had no alternatives to TennCare because the state regulations had all but destroyed the insurance market. Ironically (though predictably), TennCare ended up causing the most harm to the very people it was intended to help—rural patients and “the poor.” The program also nearly bankrupted the state.(56)

Hawaii recently received praise from the left-leaning Commonwealth Fund for being the top U.S. state with respect to health care coverage.(57) In theory, Hawaii provides nearly universal coverage for all of its residents through a combination of employer mandates and a state program called QUEST, which is an expanded version of Medicaid. In practice, however, many patients in Hawaii are unable to get essential care in a timely fashion. As the *Honolulu Star-Bulletin* reported:

A Commonwealth Fund survey said Hawaii has the best access to health care in the country, primarily because of a high number of residents with health insurance. But the study didn't consider availability of doctors, Hawaii Medical Association members say. "If we don't have doctors available to see them, what good does insurance do you?" said HMA President Linda Rasmussen, a Kailua orthopedic surgeon. High malpractice premiums and low insurance reimbursements have created a "state of crisis" in Hawaii with physician shortages limiting access to health care, she said. . . . "If I have a patient who needs a total joint (replacement) and has an abnormal EKG (electrocardiogram) and needs to see a cardiologist, it's almost three months to get an appointment before he gets cleared," she said. "If a person calls when they're 50 for a colonoscopy, they're almost 51 before they get in." . . . "People are frustrated," said HMA Executive Director Paula Arcena. "They have insurance coverage but they can't find doctors." The neighbor islands and rural Oahu are affected the worst, especially in specialty and trauma care, she said.(58)

Patients in Hawaii know the difference between "coverage" and actual care.

The Massachusetts plan, which is barely a year old, is already giving rise to the economic problems that follow logically from the government violating the rights of patients, doctors, employers, and insurance companies. The plan, which was signed into law by former governor (and current Republican presidential candidate) Mitt Romney, relies heavily on a combination of mandates requiring individuals to purchase health insurance and employers to offer it. In the name of "comprehensiveness," the state has also imposed numerous mandates on insurance companies, requiring their policies to include specific coverage that would not be sustainable in a free market. The poorest residents are given government subsidies to offset the costs, but everyone else is required to pay for coverage regardless of whether they need or desire it. This is the health care equivalent of the state requiring everyone to purchase a car, requiring car dealers to sell only expensive models such as Mercedes and Lexus, outlawing the sale of all inexpensive models, and giving subsidies to the poor so that they too can participate in the charade.

The *New York Times* has reported numerous complaints about the Massachusetts plan from small business owners, doctors, and patients. Restaurateur Deb Maguire said, "This is going to bring me to my knees," because the cost of the mandatory insurance would be "astronomical." Dr. David Torchiana, chief executive of the Massachusetts General Physicians Organization, stated that the plan "will strain what is already a shortage of primary care physicians." (In other words, it will not improve access to actual medical care.) Linda Impemba, a 58-year-old marketing company employee, said "she would remain uninsured, pay penalties, and, as soon as her ailing mother dies, will leave Massachusetts." In her words, "There's no way in heaven I can possibly survive in this state . . . Now not only is my cost going to go up, everything's going to be raised so I can pay for the other people to be insured." In response to these and similar concerns, Massachusetts Governor Deval Patrick has stated, "Ultimately we are going to have to explain to people that this is an obligation, that it is not optional."(59)

Because the Massachusetts state government does not and cannot produce actual health care, it cannot meet its goal of guaranteed high-quality, low-cost health care for all residents. Thus, until the state repeals the plan and ceases to violate individual rights, it will necessarily seek some compromise between "universal coverage," raising taxes, and rationing care. As a recent report from MSNBC.com notes:

The state has already backed off of "universal." About 160,000 uninsured people in the state have incomes that are too high to qualify for subsidized health insurance—but too low to afford the lowest-cost unsubsidized plans. About 60,000 of these working poor won't face a penalty for not getting insurance, but the 100,000 others are in a bind. "What I'm starting to see," [single mother] Maureen Linehan said, "is the people have to pay for their health care, and now they can't afford to pay their rent."(60)

As is predictable, the individual insurance mandates imposed by the state cause the most hardship for those who were supposed to benefit the most from the government program: "the poor."

Government-run health care systems do not and cannot work, because they improperly treat health care as a "right." Health care, like food and clothing, is a *need*, but not a right. It is a *commodity* that is created by the intelligent thought, creativity, and hard work of producers, such as doctors, nurses, allied medical professionals, and hospital administrators. When the government treats health care as a right, it necessarily violates the genuine rights of the providers who produce those goods and should be free to offer them for exchange on whatever terms they see fit, not forced to serve people against their own judgment. And it necessarily violates the rights of consumers, who should be free to trade with providers by mutual consent to mutual benefit. As we have seen repeatedly, good doctors cannot and will not continue working under a system that enslaves them.

A final (and often unacknowledged) consequence of government interference in medicine is that it leads to violations of individual rights in other areas of life, such as violations of the right to free speech and mandates regarding what people may and may not eat. When the government pays our health care bills, in order to save money, it inevitably demands greater control in how we lead our daily lives. Some of the “universal health care” proposals in Colorado, for instance, include “sin taxes” on foods and products deemed unhealthy.(61) And in Great Britain, the government Advertising Standards Authority recently banned television reruns of some 1950s-era commercials featuring the slogan “Go to work on an egg” on the grounds that they were promoting an unhealthy lifestyle. Eggs are, of course, legal in Great Britain, but, says the government: “Eating eggs every day goes against what is now the generally accepted advice of a varied diet. We therefore could not approve the ads for broadcast.”(62)

## **A Genuine Solution**

The solution to America’s health care problems is not more government intervention. Government violations of individual rights through government interference in the marketplace are the source of the problems. Government meddling in health insurance has all but eliminated choice, competition, and innovation, and has driven up the cost of health insurance. Government interference in medicine has caused incalculable harm to both patients and doctors, and driven up the cost of health care. Government controls have bred more controls, as politicians and bureaucrats have tried to “solve” the problems created by one set of regulations by imposing another set, and so forth, in a vicious spiral of increased costs, rationing, suffering, and death. Just as a doctor would not attempt to treat a burn victim by exposing him to more heat, so we should not attempt to solve our health care problems through more government intervention.

The only moral and practical solution to this now-behemoth problem is to acknowledge that government intervention in health care and in health insurance is wrong, and to start in earnest to eliminate all such interference. This is the moral approach to solving the problem because it recognizes that the producers of health care goods and services have an inalienable right to dispose of the fruits of their thought and labor as they see fit, seeking their best interests through free trade in the marketplace. And it is the practical approach to solving the problem because it will lead to high-quality medical care at the prices that make such care possible—the prices on which providers and patients voluntarily agree.

A first step in the right direction would be to repeal EMTALA, allowing doctors and hospitals to decide whom they will treat and on what terms, and whether they will treat a given patient at all. As a matter of moral fact, doctors have the same rights as plumbers, accountants, grocers, and lawyers—rights that include the right to decide which patients they will treat and to refuse patients who cannot afford them.

As to the question of how those who cannot afford medical care will receive it, we must bear in mind that government is not taking care of them now and is logically incapable of ever doing so, for the simple reason that government does not and cannot produce goods or services. Insofar as people who cannot afford medical care are receiving it, the care is being provided by productive American citizens, doctors, and hospitals. And we must bear in mind that, in the words of Philosopher Leonard Peikoff, Americans who cannot afford medical care “are necessarily a small minority in a free or even semi-free country. If they were the majority, the country would be an utter bankrupt and could not even think of a national medical program.”(63)

Those unable to afford any particular medical services would have to rely on voluntary charity, not on the empty promises of government. Individually, Americans are the most generous people in the world, and they have always been so. For example, American individuals, corporations, and foundations gave \$1.5 billion to aid victims of the December 26, 2004, Sumatra earthquake and tsunami, more than double the amount any government provided, including the United States.(64)

Quoting Dr. Peikoff again:

And such charity, I may say, was always forthcoming in the past in America. The advocates of Medicaid and Medicare under LBJ did not claim that the poor or old in the '60s got bad care; they claimed that it was an affront for anyone to have to depend on charity.

But the fact is: You don't abolish charity by calling it something else. If a person is getting health care for nothing, simply because he is breathing, he is still getting charity, whether or not any politician, lobbyist or activist calls it a "right." To call it a Right when the recipient did not earn it is merely to compound the evil. It is charity still—though now extorted by criminal tactics of force, while hiding under a dishonest name.(65)

As shown, charity already abounds in America and would be even more abundant if the government removed its coercive hands from the health care and health insurance industries and consumers. Even with the government violating rights to the extent that it currently does, many examples indicate the sufficiency of charity in this regard. Here are just a few: The Shriners' Hospitals provide free care to children and adults with orthopedic, spinal cord, and burn injuries. St. Jude's Hospital provides free catastrophic care for children. Pharmaceutical companies provide enormous quantities of prescription drugs to those who are unable to afford them; for instance, they provided free (or nearly free) prescription drugs to about 6.2 million people in 2003 alone, and have been providing free prescription medicines to those unable to afford them for years.(66) And there are hundreds of other examples.

With sufficient cultural support, eliminating EMTALA would be easy and would cause little disruption of services. It could be phased out over the course of a year with no difficulty. By setting a definite date in the future, for example, December 31, 2008, at which EMTALA would end, everyone would have ample opportunity to learn the law, and willing doctors, hospitals, and philanthropic organizations would have time to ramp up their charity care.

We must also eliminate the preferential tax-exempt status of employer-provided health insurance. The tax code must be changed to treat all Americans equally with respect to how they purchase health insurance and medical services. The existing unjust tax provision could also be phased out over a relatively short time, perhaps two or three years. But we must begin today by recognizing that this tax law is unjust both to those without employer-sponsored insurance and to those with such insurance. It gives preferential tax treatment to those with health insurance, and it treats those same employees as helpless dependents by making it economically unsound for them to choose and pay for their own insurance plans.

Further, we must eliminate all insurance mandates—including mandatory community rating, guaranteed issue, guaranteed renewability, and benefit mandates—and we must emphatically reject any call for individual or employer mandates. Insurance companies have a moral right to offer whatever policies and terms they deem marketable. Under a free market in health care, the types of insurance plans and coverage will undoubtedly change, but such changes will be the result of insurers and consumers acting according to their best judgment—by mutual consent and in each party's best interest. That is the beauty of a truly free market.

Some states have already begun to curtail benefit mandates. As we mentioned above, Kentucky called for a three-year moratorium on all new mandates; consequently, the market in that state has begun to revive. To enact such measures across the country and to sustain them over time, however, Americans must come to understand that mandates are immoral and impractical and that, consequently, they do harm, not good.

We must work toward the elimination of Medicare, Medicaid, and all other government insurance programs that allegedly benefit the aged and the poor. As we have seen, these programs provide illusory "coverage," while actually reducing or eliminating patients' access to doctors. These programs could be phased out over several years beginning with the passage of a law to the effect that no person under the age of thirty-five will pay into or receive any benefits from Medicare. This would enable those under thirty-five to begin planning for their own future, long-term medical costs and enable insurers to plan for the future as well. Likewise, we could start reducing both the extent of Medicaid benefits and the number of beneficiaries, by limiting the number of years that a person could receive Medicaid benefits, in ways similar to those methods used very effectively by the Clinton administration to reduce welfare rolls.

Finally, we must repeal HIPAA and all other government regulations involving health insurance or medical care. It is immoral for doctors to be subject to criminal penalties for documentation errors that violate no rights and have nothing to do with the quality of patient care. These laws do nothing but increase the amount of time spent on useless, or nearly useless, paperwork. Eliminating HIPAA and many other regulations would enable doctors to return to the practice of medicine, providing patients with more access to quality care. Again, eliminating these laws could be done easily, by setting forth a future time at which the law would expire.

One innovative insurance solution that is likely to become commonplace in a truly free marketplace is a combination of Health Savings Accounts (HSAs) and high-deductible, low-cost catastrophic insurance. HSAs enable individuals to save money for possible future medical expenses and to spend their own money on routine health care according to their own best judgment. Catastrophic insurance provides an economical way to protect against low-probability but highly expensive accidents and serious illnesses. Economic analyses have shown that a combination of these two kinds of plans provides high-quality care at a lower cost than traditional insurance plans.(67) The Whole Foods grocery chain, for example, has been successful in using HSAs in conjunction with high-deductible catastrophic insurance policies to cut costs, while encouraging individual responsibility and preserving quality of care. This program is extremely popular with Whole Foods employees.(68)

Although the goal of these proposed changes—a fully free market in health care and health insurance—cannot be achieved overnight, movement in the right direction can and should begin immediately. The only moral and practical way to proceed is to recognize the proper end and to consciously and consistently move toward that end by taking whatever steps in that direction are possible at any given time. What we must not do is shy away from recognizing and proclaiming the proper goal—the complete eradication of every trace of government interference in medicine and health insurance—or the fundamental moral justification for pursuing that goal: the individual’s moral right to his life, liberty, and property.

Only the ideal of the free market—based on the principle of individual rights—provides a solid foundation for genuine and practical reform. And only a free market in medicine can deliver the properly (i.e., voluntarily) priced high-quality health care that Americans deserve. This last point is evident in the sectors of medicine with the least government regulation, such as cosmetic surgery and LASIK eye surgery. The clear pattern in these sectors is a continual decrease in prices and improvement in quality. As health economist Devon Herrick stated in testimony before the U.S. Congress:

[D]espite a marked increase in demand between 1992 and the present, cosmetic surgeons’ fees remained relatively stable. The average increase in prices for medical services from 1992 through 2005 was 77 percent. The increase in the price of all goods, as measured by the consumer price index (CPI), was 39 percent. Cosmetic surgery prices only went up about 22 percent. Thus, while the price of medical services generally rose almost twice as fast as the CPI, the price of cosmetic surgery went up slightly more than half as much. Put another way, while the real price of health care paid for by third parties rose, the real price of self-pay medicine fell. Another example of price competition is the market for corrective eye surgery. In 1999, only a few years after LASIK was approved, the price was about \$2,100 per eye, according to the ophthalmic market research firm MarketScope. Within a short time, competition drove the price down to slightly more than \$1,600. The cost per eye of the standard LASIK is now about 20 percent lower than six years earlier. Competition held prices in check until a new innovation arrived for which patients were willing to pay more. By 2003 surgeons began to perform a newer, more-advanced custom wavefront-guided LASIK procedure.(69)

In other words, the market can and does bring down health care costs while improving services when allowed to operate without government interference.

A free market in health insurance and health care works because it recognizes that health care is a commodity produced by individuals who have a right to offer that commodity for trade on whatever terms they see fit—and that consumers have the right to accept or reject those terms as they see fit. When all parties are free to trade voluntarily, according to their own best judgment, the result is lower costs and higher quality—a fact that is evident throughout the economy and recognized by all reputable economists.

The relatively-free American marketplace has done a magnificent job in providing other necessities of life such as food, shelter, and clothing; it can do the same for health care and health insurance—if we free up these markets.

In a truly free market, other creative and innovative solutions will arise—solutions that have not yet been conceived by any politician, policy analyst, or by the authors of this article. The fact that we cannot foresee all the possible good ideas is not an undesirable “bug” of the free market but rather one of its marvelous features. Just as someone twenty years ago could not have imagined the specific innovations and benefits that would arise from a free market in the then-fledgling internet industry (consider eBay, Amazon.com, Google, iPhones, etc.), so people today cannot imagine the specific innovations and benefits that would arise from a free market in medicine and health insurance. What is certain is that the freer the market, the more innovation and benefits will arise.

## **Conclusion**

We have seen that the myriad problems with American health care and health insurance are the result of decades of government interference in the markets for these goods and services. The systematic violation of the rights of health care providers and insurers to freely produce and trade goods and services has created a dysfunctional system that has harmed countless providers, insurers, employers, and patients.

We have also seen that more government control of medicine and health insurance is not the solution. Evidence and logic show that government interference in the market leads only to rising costs, rationing, and needless suffering and death.

The current system is unsustainable. Unless policy changes are made, American health care and health insurance will not remain in their currently dysfunctional conditions; they will necessarily get worse (recall that health care costs are rising far more rapidly than the rate of inflation). One way or another, the current situation will change. We do not have a choice in that matter, but we do have a choice as to the direction of that change.

America stands at a crossroads. We can continue to recycle the failed ideas of the past, continue to violate individual rights, and impose more government control on medicine and health insurance in a futile attempt to salvage a fundamentally flawed system by extending and building on its flaws. Or we can stand on moral principle, respect individual rights, begin dismantling the broken system, and start working toward a free and therefore thriving market in medicine and health insurance.

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