Chronic Condition

Why Health Reform Fails

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Harvard University Press
Cambridge, Massachusetts
London, England
1997

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Financing Health Care: A Proposal

The failure of the Clinton health plan leaves the United States without a formal system of universal medical care coverage and with an increasingly threatened informal safety net. Federal, state, and local governments, facing mounting budget pressures, are hoping that a greater reliance on managed care will allow them to maintain quality while they cut back on spending in public health insurance programs. Private cost containment efforts have sharpened competition among hospitals, weakening their financial ability to provide care to those without insurance. These public and private efforts can save money in government budgets and workers' wallets today. They cannot stop health care costs from rising in the future.

Health care costs will rise because medicine will be able to do more for people. Most Americans will grumble about the increase in costs but they will pay for more care, just as they have for the past 65 years. People who cannot see well will gladly work more hours to fund better eyesight, when medical advances enable them to do so. People who cannot walk will willingly move to smaller dwellings if doctors offer them a chance to purchase physical mobility in exchange. More people will undergo screening tests—and costly treatment—for cancer when those tests become less uncomfortable. People at risk of strokes will skip vacations to buy artery cleaning that promises to diminish these risks. People in pain will sacrifice much of their other consumption for

respite. People whose incomes rise will buy more health care without giving up anything they have today.

Simply put, health care costs will continue to rise. Governments, however, will find it ever more difficult to pay the cost of care for people in public programs. Once again, the Congress will thrill to the cries of fraud, waste, and abuse. Policy analysts will testify that one or another strategy will save billions of dollars while providing better care. If past history is a guide, the outcome will be more regulation combined with a further deterioration in the regular stream of funding of care for the poor. Yet, surprisingly, this outcome is avoidable. The problem of funding care for the poor when costs increase is one that people once knew how to solve.

Before continuing, I want to make it clear that funding care for the poor is not the only problem facing the health care system. As I have pointed out, the current system as well as medicalist and marketist reform proposals all suffer from a variety of further problems. But funding care for the poor is a particularly pervasive and intractable problem. Nevertheless, as I describe below, a straightforward solution can be incorporated into either type of health reform approach.

How America Once Cross-Subsidized Health Care

In better days long ago, before health insurance and government regulations, hospitals and physicians served their communities, or so the popular imagination holds. Neighborhood doctors treated everyone, varying their fees according to patients' abilities to pay for treatment. They served the most impoverished patients as an act of charity, charging nothing or only token fees. The local doctor might have been more deferential and zealous in responding to the needs of wealthier patients, and he (seldom she, back then) would probably recommend more costly treatments for them; but the poor got treatment too. Communities constructed hospitals to provide care for all, charging more to patients who could pay more and financing the care of the poor from the excess revenues earned from treating wealthier patients (Stevens 1989). Again, the poor might have worse accommodations, in public wards rather than private rooms, but everyone who needed treatment would get it.

Wealthier patients did not object to overpaying for their care—either because they approved of the charitable objectives that necessitated that overpayment or, more likely, because most wealthy patients had no other place to go. With only a very few doctors and hospitals in a community, paying patients would have been hard pressed to find medical services at lower prices even if they lacked charitable impulses. Physicians and hospitals could use their monopoly power to extract more dollars from paying patients.[1] Some used those extra dollars to fund care for the poor (although many others undoubtedly did not).[2]

The kind of cost shifting that once happened in mythical America provided a remarkably good solution to the problem of redistributing medical care. Charging more to paying patients to subsidize care for the poor meant that health care funding kept pace with improvements in health care technology. The poor always received less care than did paying patients, but relative levels of spending did not change over time. Paying patients implicitly took the poor into account when they made their own health care decisions. Choosing more care meant paying more directly and paying more in subsidies. Only care that was valued as much as the sum of direct costs and overcharges was purchased. That is, without necessarily recognizing it, paying patients would only buy care for themselves if they were also willing to buy more care for the poor.

Technological Change: Cost Shifting, Medicalist Models, and Marketist Models

In such a cost-shift world, the level of medical spending and the rate and nature of medical-technology diffusion are endogenously determined and take equity concerns into account. Individual consumers, through their own spending decisions, determine whether more money should be spent on medical care for themselves and for others. This endogeneity contrasts both with the central determination of spending levels required by the medicalist model and the disjunction between individual choices and equity concerns implicit in the marketist model.

In a medicalist system, a tax on income subsidizes health spending. If health care costs rise as a share of national income, the government must raise marginal tax rates to fund the new spending. Governments must weigh the political and economic costs of such increases against the benefits of higher health spending. Over time the level and pace in

change of spending that a sensible government would choose would fall below the private spending choices of higher-income people.[3] Equity can most easily be attained at relatively low levels of spending (see Lindsay 1969).

If government sets the overall level of spending, the gap between that level and privately desired spending will increase as innovations occur. The system will appear "underfunded" and those who can afford it will seek ways around prohibitions on private care. A two-tiered system will emerge, complete with disparities between private and public care that offend the medicalists' egalitarian views about health care.

Marketists give most of the decision-making power in the system to individuals, as in the cost-shift world. When innovations occur, each person decides whether to buy them or not, and each person finances them by working harder or giving up other goods and services. Here too, however, decisions about spending on the poor must be made through the political system. Although a much smaller share of health care spending would be tax financed, this model, too, would have to balance political and economic concerns about raising taxes and diverting money to fund health spending. As the tax costs of funding health care rise, the economic consequences of allowing costs in the public sector to rise will also increase. A rational government would not permit costs of care to rise as quickly in the public sector as in the private sector. With public costs growing more slowly, the relative level of care provided to those in publicly funded programs would decline (Newhouse 1994).

Technological progress over time will bring a growing disparity between privately purchased care and publicly funded care. The initial desire for a more equitable system will be squashed by the burden of the continually rising taxes needed to finance it. If the interest in equity resurfaces, the political response will be to control the system by intervening in the private market. This is exactly the pattern proposed in the Clinton plan: markets would be permitted to work only if public funding could keep up with them.

A Theory of Health Care Redistribution

Redistributive concerns in the United States focus on ensuring a more egalitarian distribution of health services than would occur without intervention in the market. Rather than treating health care as one component in a bundle of money, goods, and services provided to the poor, Americans have a specific interest in the distribution of medical services. The goal of providing and maintaining a more equitable distribution of medical services can be achieved either by pulling down the level of care of the prosperous or by raising the level of care for the indigent. Either approach will narrow the gap.

One side of the gap has been addressed on a theoretical level in previous economic analyses. Analysts of the economics of redistribution in health care have argued that society's interest in providing medical services to the poor can generate what economists call an externality—an effect on people who neither receive nor provide the services (Lindsay 1969; Pauly 1971). If people care about providing the indigent with health services, then public financing of those services has two kinds of benefits. First, it benefits the poor directly because they get health care. Second, it generates external benefits (externalities) to nonindigent people who are made better off by knowing that the poor have received care. Even people who play no part in these transactions, neither paying taxes nor receiving free health services, may benefit psychically from the provision of these services. The existence of these externalities provides an economic justification for public financing of some level of health care for the indigent.

By the same token, those who value an equitable distribution of health resources are affected by private decisions by the nonpoor to increase their own health spending. More health spending by the prosperous widens the gap between rich and poor in just the same way that an increase in spending on the poor narrows it (Lindsay 1969). The private decision to pursue more costly and aggressive treatment affects the well-being of *all* Americans by changing the notion of what constitutes adequate care for the indigent.

In practical terms, an improvement in the quality of care selected by the prosperous has significant social implications in an environment that values health service equity. A private decision to increase spending must have one of two undesirable consequences: either health care equity will decline or the government must increase spending on the public program. In the latter case, balancing the government's budget will mean either reducing spending on other valuable public programs or raising tax rates and triggering the economic distortions associated with

higher rates. Generating an equitable distribution is simply much more costly at higher levels of health spending than at lower levels.[4] Thus private decisions about spending levels, which appear to be of no economic interest to third parties, can have substantial public implications.

The cost-shifting model internalized this externality. Higher-income patients paid more for services than did lower-income patients. The system explicitly redistributed health services. In effect, the financing system generated cross-subsidies between those who could afford to purchase care and those who could not.

Recent innovations in the treatment of myocardial infarction (heart attacks) using drugs called thrombolytic agents provide a vivid example of the problems involved in addressing these externalities in today's health care sector as well as under a medicalist or a marketist reform. In late 1987 the U.S. Food and Drug Administration approved a new thrombolytic drug, t-PA, for the treatment of heart attacks. Early studies suggested that t-PA was somewhat more effective in reducing mortality from heart attacks than was another recently introduced thrombolytic drug, streptokinase. Streptokinase, though, costs only one-tenth as much as t-PA (Burke 1993).

In 1988 the government of Ontario, under a medicalist model, decided not to reimburse hospitals for the costs of using t-PA for any patients with heart attacks. The government argued that data on the effectiveness of the drug were quite incomplete and that the benefits did not yet appear to justify the added costs. Canadian health system rules prohibited hospitals from accepting payments from patients who wanted to receive the drugs. Faced with limited funding, hospitals restricted the use of t-PA and a survey found that doctors administered streptokinase about three times more frequently than t-PA (Naylor et al. 1990). In the United States, under a (more or less) marketist model, use of t-PA grew rapidly after its initial approval. Surveys in 1989 found that 60 to 80 percent of physicians primarily used t-PA rather than streptokinase in their practices (Brody et al. 1991; Lessler and Avins 1992). Economic considerations did affect the choice of drugs. Doctors in health maintenance organizations were much more likely to use streptokinase than were other doctors (Lessler and Avins 1992). Uninsured patients, Medicaid patients, and patients in public hospitals were also relatively more likely to receive streptokinase than they were t-PA, but, according to survey responses, even these patients were likely to receive t-PA about half the time.[5]

In Canada the introduction of t-PA meant an increase in the gap between the amount of health care people would choose for themselves and the amount provided under the public program. While many Canadians would have voluntarily selected lower-cost care and chosen streptokinase over t-PA, many others undoubtedly would have spent more to receive the slightly better drug. Under the medicalist system, this choice was entirely barred. Canada avoided the inequality associated with higher levels of use by higher-income people, but at the cost of making this group worse off without making anyone else better off.[6]

In the United States, the rapid spread of t-PA brought both a further divergence in the quality of care received by uninsured, Medicaid, and privately insured patients and an increase in the costs of programs that provide care to the poor (since some uninsured and Medicaid patients did receive t-PA). Privately insured patients who chose the drug, though, had no incentive to consider these further consequences. Private choices led to effects on third parties that were not taken into account by those who made the choices. Those who strongly valued health equity were made worse off by the increased divergence in the nature of care; those who pay taxes were made worse off by the increased cost of care. These negative effects can be seen most clearly in the case of heart attack patients who had joined HMOs. These patients bore a double burden: they were less likely to receive t-PA themselves than were those who chose more costly insurance plans, but they still paid the higher taxes associated with financing t-PA for indigent patients.

Neither the United States nor the Canadian system gets it right. The Canadian restriction on the use of a costly drug made those who would have chosen the drug worse off, without in any direct way benefiting those who could not afford the drug. The American system allows private decisions to have haphazard, unconsidered effects on the publicly funded health system—effects that drive up costs and reduce equity. Neither system does what the American goal of health redistribution suggests it should do: redistribute health care from those who choose a lot to those who cannot afford enough.

A Model for Financing Health Care

In today's health care marketplace, the mythical golden era of cost shifting, if it ever did exist, cannot be resurrected. Doctors and hospitals compete energetically for business and cannot compel well-to-do pa-

tients to pay extra for services. Managed-care organizations solicit bids from hospitals and use price as an element in their contracting. Hospitals and physicians who hope to find business cannot charge more than competitors do. In most parts of the country, the power of physicians and hospitals to charge extrahigh prices to certain patients to offset discounts for others has disappeared.

The structure of the health services industry has also changed in ways that make informal cross-subsidies impossible to resurrect. The proliferation and diffusion of services that exist in today's market, including freestanding diagnostic and surgical clinics and legions of local specialists and subspecialists, mean that many physicians and health service facilities do not serve a diverse cross-section of the population. Patients spend only a day or two in the hospital, not long enough to feel a special connection to the particular facility. Many physicians treat only rich people or only poor people, thus eliminating the possibility of charging more to some to provide care for others. The very existence of publicly provided insurance financed by taxes may reduce charitable donations to hospitals (Sloan et al. 1990).

Although the possibility of returning to America's mythical age of health care financing has disappeared, the appeal of the myth endures. People who benefit from the miracles of medicine should, it suggests, share their good fortune.[7] Hospitals exploit this idea when they solicit former patients to endow new equipment, clinics, or buildings. They anticipate that gratitude for treatment received will fortify the prospective donors' charitable impulses and generate donations from them. Anecdotal evidence suggests that this strategy is quite successful.[8]

Can the benefits of a cost-shifting system be resurrected? I believe that they can, through a two-pronged approach: taxing health care spending and redistributing funds according to income.

Raising Funds

A tax on health care providers would address three concerns. First, it would provide funding to finance health care for the poor. Second, it would force the more affluent to take into account the way their health purchase decisions affect the level of health care that society chooses to provide to the poor. Finally, in so doing, it would make the level of sustainable national health spending an outcome of a private decision-

making process, not a constraint imposed arbitrarily from above. Health care financing would mimic the dynamic nature of health care itself. Health care revenues would rise when costs rise.

The health tax would be levied on all suppliers of health services: doctors, hospitals, freestanding surgical centers, pharmacists, insurers, and managed-care companies. Services paid by insurance would be taxed through a levy on premiums, and services financed through out-of-pocket payments would be taxed directly. Eventually, most of the cost of this tax would be passed along to service purchasers in the form of higher prices.[9] All services would be taxed at a single, unchanging tax rate. If people, on average, chose to purchase more costly services, the tax would yield more revenue, but the rate would not change.

People who chose more costly health care would pay more in taxes (a flat percentage of a higher price) than would those who were more frugal in their health care choices. In the example of the choice of t-PA and streptokinase described above, the prices of both drugs would reflect the same tax rate, but the price of t-PA would include a higher absolute dollar amount of tax revenue than would the price of streptokinase. Purchasers of t-PA would contribute more to the provision of thrombolytic drugs (or other care) to the indigent than would users of streptokinase. Total consumption of thrombolytic drugs (measured in terms of dollar-valued units) would decline as a consequence of the tax.

Tax revenues would be used to subsidize health services for people with low incomes. The effect of the subsidies would be to provide more health services to those who could not otherwise afford them, benefiting both the recipients of services and those concerned about the equitable distribution of medical care. The amount of the subsidy provided would depend on the amount of tax revenue collected. As health care costs rose, more revenue would be collected and the per capita subsidy would rise. If high-income purchasers became more frugal in their health care choices or if technological improvements led to reductions in the cost of care (see Schwartz 1994), subsidies would decline. The revenues raised to redistribute health care would wane and wax along with health spending.

From a tax policy perspective, a tax within the health services sector would have few distortionary effects. If my reasoning above is correct, health care usage generates externalities in the form of growing in-

equities; a tax on health care would, in effect, force health care purchasers to consider the impact of their decisions on others.[10] They are likely to respond by spending less on health care out-of-pocket and less on health insurance (Phelps 1976). One likely way for consumers to reduce spending on health care and health insurance is to choose plans that incorporate more restrictions on service use, such as HMOs or high-deductible traditional insurance plans.

How large is the health care consumption externality? Today, the typical uninsured individual receives about 60 percent as much care as does the average insured person (adjusting for health status).[11] The fact that that figure has remained roughly constant since about 1957 suggests that it may represent underlying social preferences about the relationship between minimum adequate care and average privately financed care. A one-dollar increase in health consumption by an upper-income American appears to lead people to increase the minimally adequate bundle of care available to the poor by 60 cents. This concern about assuring minimally adequate health consumption may encompass the population with incomes below 200 percent of the poverty line, about one-third of the U.S. population. Under these assumptions, a health tax rate of 30 percent would correct for the external effects of health care consumption. If the extent of redistribution desired was lower or the population of concern was smaller, the tax rate would be correspondingly smaller too.[12]

The health tax rate should be constant across the nation. In areas where health costs are high, the tax would collect more revenue. Unlike financing proposals that focus exclusively on the decisions of individuals at the margin, the flat health tax proposal encourages regions to make considered decisions about the average cost of care. Areas that chose to raise the cost and quality of care by building elaborate new health facilities could do so, but they would pay more in taxes. Just as the health tax would force individuals to consider the broader implications of their health care choices, the tax would encourage states and localities to consider the full costs of their health planning decisions. A single national rate would avoid the problem of a "race to the bottom" among states and localities. By maintaining a single tax rate across the nation, jurisdictions would compete only by reducing the cost of care for all, not by cutting services to their poorest residents.

In its effects, the health tax I propose is the mirror image of the existing tax treatment of employer-provided health insurance. The tax treatment of health insurance gives people an incentive to consume more health care; the health tax would give them incentives to consume less care. The current tax treatment provides the most government support to high-income taxpayers who choose costly care; the health tax imposes the smallest burden on those who choose frugal plans. The tax treatment of health insurance shifts the burden of health care spending from regions with costly utilization patterns to regions with thrifty ones; the health tax ties costs to the region in which they are incurred. The tax treatment of health insurance drains government coffers when health costs rise, making it ever more difficult to finance care for the indigent; the health tax replenishes the treasury when costs rise, making it easier to finance care for the indigent.

Unfortunately, simply abolishing the tax treatment of employer-provided health insurance benefits would not achieve the goals of the health tax. Eliminating this special tax treatment would reduce the effects on government budgets of increases in private health costs, but it would not generate a stream of new revenues to offset the costs of those who require subsidies. Eliminating the tax treatment is an important step toward developing a sustainable financing system, but it does not take us far enough.

The need to generate a politically acceptable stream of new revenues has led many state lawmakers to consider using provider taxes to fund health care benefits. A number of states have proposed financing some care through taxes on hospitals or providers (for example, see Crittenden 1993 for a description of the Washington State plan and Leichter 1993 for a description of the Minnesota plan). Premium and provider taxes are used in many states to raise funds for high-risk insurance pools and other redistributive functions. In New York State, uncompensated care and graduate medical education in hospitals is financed through a 13 percent surcharge on hospital care paid only by those with private commercial insurance (not Blue Cross coverage). The tax raises over $3 billion annually (Alpha Center 1995). The health tax proposal described above provides a rationale for this increasingly popular kind of state health care financing.

A health tax could raise a substantial amount of money for redistribution. A 30 percent tax on the $782.5 billion Americans spent on health care in 1993 might reduce health care spending by 5 percent

the vast majority of the poor themselves. By recognizing that society's interest in health services redistribution is distinct from its interests in other kinds of redistribution, the health tax removes the question of funding health care for the poor from the broader issue of assistance to the poor. This will enable policymakers to devote appropriate attention to the general needs of the poor, undistracted by surges in health care costs.

In this sense, the health tax runs counter to the original marketist idea that health care redistribution is simply a politically feasible way of achieving a more equitable distribution of social resources in general. Treating health care as an element in overall resource redistribution has, until now, had the perverse effect of further impoverishing the poor when health care costs rise. Society has an interest in the redistribution of health care, but liberals cannot piggyback general redistribution on that interest. Health care redistribution can transfer health care resources to achieve a more equitable distribution of these resources, but it cannot successfully do more than that.

The health tax recognizes that health care redistribution cannot achieve general social equity. Indeed, its design also embeds a degree of inequality and means-testing into the distribution of health care itself. The health tax cannot and is not intended to generate a perfectly equal distribution of health services that reflects medically determined needs for services. But it can generate a perpetually rising level of adequate care for those in need, a level that improves as health care improves.

In Defense of a Multitiered Health Care System

The cost-shift world—and the health tax world—do not generate a perfectly equitable distribution of health care, as the medicalist model would. Rather, they generate a multitiered system of health care. Poor patients receive considerably less care, in less comfortable circumstances, than do those with more money. What do such inequities imply about health care?

The experience of a broad range of other countries with very different health systems suggests that it is possible to provide people with a fairly high level of basic health care for half as much as the amount spent (per capita) in the United States. In general, other countries do

not achieve these results by making difficult and explicit rationing decisions such as denying services to people in certain categories (for example, those over seventy) or prohibiting the use of new treatments. Rather, they achieve their results by slowing the introduction and diffusion of new technologies, concentrating costly procedures at a limited number of centers, delaying access to expensive care, and using more generalists and fewer specialists.

It is important to recognize that the costs of these strategies are real ones. As recent studies comparing Canada and the United States suggest, patients in cost-contained systems may experience more discomforts and delays than patients who spend more money. Delays in access to high-technology care will, in some instances, lead to worse health for particular patients than might have been achieved through speedier treatment. Most evidence, however, suggests that on average these differences in access to costly services have minimal effects on overall physiological health.

Some would even argue that these expenditure-reducing strategies have benefits as well as drawbacks. Requiring patients to wait for treatment certainly imposes costs on the patients, but it allows higher use of existing health care capacity and may lead some patients to decide to forgo treatment after thinking through their situation more carefully. Concentrating procedures in a few centers adds to patient inconvenience, but it helps to ensure that those performing procedures have more experience. Reducing the pace at which new technology is introduced means some people are deprived of procedures that might help them, but others are spared procedures that turn out to do more harm than good. Using more generalists may mean that doctors have less knowledge of the latest developments in a field, but they may be better at managing the patient as a person.

While allowing those who could afford it to avoid discomforts and delays, a multitiered system would guarantee a level of care to all that was equivalent in cost to that provided in most other countries. The cost-saving strategies employed by other national health systems could readily be (and are being) adopted by frugal managed-care companies. These companies, operating on a fixed budget, could offer adequate but low-intensity care to those who cannot afford more. Those who really care about having their knee operation next week and not in two months, or seeing a subspecialist rather than a general practitioner, or

being treated in a modern, high-technology local facility rather than a central hospital can pay more for these valued benefits.

Under a health tax, this group would also contribute more to care for the poor. A health tax would not produce a two-tiered health system: it would produce a multitiered health system. Some people would receive care at the defined adequacy standard, others would buy somewhat more care than that, and some would choose superluxury care. No one would go without care, but some people would receive more and probably better care than others. The world of widely diverging incomes would continue to generate an unequal distribution of health care. But the tax could be relied on to produce revenues sufficient to assure that the lowest level of spending was in constant relationship to higher levels of spending. A gap between the rich and poor would remain, but it would not widen. The quality of care available to the poor would rise as the quality of care purchased by the affluent rose.

The health tax can permit inequality because it avoids a common concern about nonuniversal programs. Policy proposals often call for an equal, universal benefit because proponents fear that without middle-class support the program they are pitching will eventually be underfunded. The health tax would generate a growing stream of income over time without requiring increases in tax rates. While the health tax will not bring equality, it will proscribe growing inequality.

How Would a Health Tax Work in Practice?

A health tax and subsidy program would generate a health care system that falls somewhere between a marketist and a medicalist model. Health care would not be distributed perfectly equitably, but equity considerations would enter all decisions. A health tax could be incorporated into either a marketist or medicalist system of health reform.

Consider, for example, a very simple marketist reform that gives currently uninsured low-income people health insurance vouchers and has them seek care in the marketplace. This kind of reform might also include the development of insurance-purchasing organizations and a system of risk adjustment to respond to adverse selection and risk selection problems (see, for an example, the Bush health care proposal, described in CEA 1992). In this model, the health tax would raise revenues for vouchers for redistribution. The existing Medicare program would continue, but Medicaid might be incorporated into the voucher system. In order to fund this new voucher program, the health tax would have had to raise about $150 billion in 1993.[14] A 30 percent tax on all private health insurance and out-of-pocket payments would raise this sum (while the income taxes and other levies now used to fund Medicaid and uncompensated care could be eliminated). Note that incorporating the health tax into this marketist proposal does draw it part of the way toward the medicalist camp. Funding health care through a tax on health ties the spending decisions of higher-income Americans to those of lower-income Americans in a way that a proposal based on other taxes would not. At the same time, the health tax protects the market from the excessive regulation and pressure for systemwide cost containment that otherwise accompany increases in the cost of government programs.

A health tax could also be used as an element of a more medicalist, single-payer health program like the Canadian health care system. Under a health tax proposal, hospitals, physicians, and other providers would be allowed to opt out of the existing fee schedule, forming a separate private system of care. The private system could be reimbursed by private health insurance or out-of-pocket payments.[15] All services rendered in this private system would be taxed at the health tax rate. The funds raised from the health tax would be used to enrich the existing public system.

Suppose, for example, that 25 percent of the population chose to participate in the private system and initially spent an average of $1,000 in that program. A 30 percent health tax rate would ensure that for the next 20 years average spending by those who opted out would be no more than 30 percent higher than per capita spending in the public system, even if spending in the private system grew twice as quickly as spending financed by income taxes in the public system.[16] Furthermore, a 30 percent tax rate on private spending would allow the total funding of the public system to grow a little faster (about 0.1 percent per capita faster) than it would otherwise. Unlike other two-tier models, equity in this system would grow if more people opted into the private sector or if those who used the private sector reduced their spending in the public sector. Rather than leading to further underfunding of the public sector, under a health tax these changes would reduce average disparities in spending and lead to faster growth of the public sector. Again,

adding a taxed private sector to a medicalist system would draw it part of the way into the marketist camp by introducing some inequity into the system. At the same time, by reducing cost pressure, a health tax could be used to protect medicalist interests in the integrity of the public sector of the system.

Conclusion

The health tax model addresses only one of the many problems inherent in marketist or medicalist health reforms. But the problem of funding the system over time, the problem that the health tax is intended to address, in practice eclipses all the other failures of regulatory design. Without money, there can be no real health reform.

Any health system reform will be undone without a stable, growing source of funding. A medicalist reform, faced with diminishing resources, will further constrain the growth of services. Attempts to save money will lead to increased micromanagement of medical practice, undermining the medicalist interest in empowering physicians. Constraints will also squeeze the political consensus that maintains the system. Wealthier people will opt out and their support for tax financing will diminish.

A marketist-oriented reform, like the managed competition considered by the Clinton administration, will also be undone by funding woes. With health care spending rising more rapidly than incomes or economic output, a broad-based tax—which is a tax on overall economic activity—will over time fall short. The government can, for a time, broaden the tax base, as it did in funding the Medicare trust fund, or it can raise rates; but ultimately, increasing costs will require the government to take an active hand in forcing costs down. Any public program thus raises the specter of more and more government cost containment—with government regulation eventually intruding into the private health care sector.

Everybody wants health care reform, but nobody wants to pay for it. The rift between people's charitable sentiments toward the poor and their proprietary feelings toward their pocketbooks has been the bane of health reform. But this time the public is right. None of the solutions advanced to address the problem of health care redistribution up to now will work in the long run, and Americans should reject all of them.

One solution, emphasized in recent debates over the Clinton plan and Medicare reform, is to apply the efficiency gains from reforming the system to fund care. But although improving the system can save money, it simply will not save enough to cover the costs of care ten or even five years from now. Efficiency savings are onetime-only events. Given the dynamic nature of medical change, they cannot provide a stable base for funding care for the uninsured in the future.

A second way to fund health reform is by imposing constraints on existing public programs. If Medicare and Medicaid grow more slowly than currently projected, the additional revenues that would have been needed to fund these programs can be diverted to the uninsured. Unfortunately, there is little evidence to suggest that cost growth in Medicare and Medicaid have been substantially different from cost growth in the private sector. Over time, achieving lower rates of growth in these public programs would yield a widening gap between the quality of publicly funded and privately funded care. That gap could be eliminated only by making the private system grow more slowly too. Making the private system grow more slowly means restraining private spending decisions. That is neither politically feasible nor economically desirable.

Hardheaded reformers assert that the public should be made to bite the bullet. Those who want universal coverage should be prepared to pay for it through higher broad-based taxes. Here too, the public says no and the public is right. Broad-based taxes are not the answer to health reform. In the long run, they just won't work. With health costs growing faster than the economy as a whole, broad-based taxes will not raise the stream of revenue needed to assure that care for the poor keeps pace with improvements in care for everyone else. Either the gap between rich and poor will widen, or tax rates will have to be continually increased.

The health tax model I propose can provide a long-term basis for funding health care equity. It takes the growing level of private health consumption and redirects part of it to fund health care for the poor. It is a revenue source that will grow along with the need for the revenues. Finally, a provider tax fits popular perceptions about how health care should work by making the beneficiaries of modern medical care share its rewards. It updates the mythical vision of community health care to correspond with the realities of medical care today. It maintains a level of equality in the distribution of health services. It generates a level of health care spending that both the nation and the government can afford—today and twenty years from now.

In some colleges more than one-third of the cost of tuition goes toward financial aid (Goldin 1995).

2. As early as 1929, 13.6 percent of health care in the United States was publicly funded (Department of Commerce 1975).

3. For example, higher tax rates will deter some people from working more hours and thus reduce the size of the economy.

4. Consider a hypothetical country that contains 80 people who earn $30,000 a year and 20 who earn only $5,000 a year. Suppose, initially, that the higher-income group spends 5 percent of its income on health care, an average of $1,500 each, while the low-income group averages $500 a year (10 percent of income) on self-purchased care. If this society decides that an appropriately equitable distribution of health services would provide the poor half as much care as the rich receive, the average poor person would have to receive $250 more care. This sum could be financed through a 0.2 percent tax on the incomes of higher-income tax payers. Now, though, suppose that a new medical innovation is introduced that prompts higher-income people to double their health spending and lower-income people to increase spending by $40. In order to restore the same level of equity in the distribution of health resources, transfers to the poor would have to be increased to $960, necessitating a quadrupling of the income tax rate to 0.8 percent.

5. Brody et al. (1991) found that 69 percent of physicians in federal public hospitals and 47 percent of physicians in nonfederal public hospitals used streptokinase rather than t-PA. Since about 15 percent of all public hospitals are federal hospitals, this suggests that the weighted average of streptokinase use in public hospitals is 50 percent. Lessler and Avins (1992) found that among the 79 percent of physicians who primarily were using t-PA, 36 percent would switch to streptokinase for a self-pay patient and 27 percent would switch for a Medicaid patient. Physicians who primarily used streptokinase were heavily concentrated in health maintenance organizations.

6. The amount by which they were made worse off depends on the extent to which they *believed* t-PA was a superior drug, not necessarily the actual differential in quality.

7. Many people do complain about "cost shifting" in today's health care market. Privately insured patients complain that reductions in prices paid by the government for health services mean higher prices for them. Employees of large firms assert that they pay higher costs to cover uninsured workers in smaller firms. Actually, in today's health care market, it is unlikely that either outcome occurs. Competing firms, insurers, doctors, and hospitals will almost certainly eliminate the possibility of such "dynamic" cost shifting (see the discussion in Morrissey 1994). Nonetheless, these complaints imply not so much that cost shifting itself is inappropriate than that the burden of caring for the poor is unevenly allocated so that not everyone is paying a fair share.

8. For example, the chairman of MCI communications, William McGowan, donated $1 million to the hospital where he had undergone a heart transplant operation (Brown et al. 1990). A philanthropist in Gross Pointe, Michigan, who later died of cancer, donated $3 million for treatment of the disease to a Detroit hospital ("Hospital Benefactor" 1989). A physician in Washington, D.C., made a small donation to a fund-raising campaign for the hospital that had saved her life as an infant 33 years earlier (Levey 1994).

9. The demand for health services is relatively inelastic (unresponsive to prices), while the supply of services, especially in the long run, is likely to be relatively elastic (responsive to prices). This means that most of the tax will be borne by patients.

10. A tax on health care also makes sense under a more pragmatic analysis that entirely rejects the externality argument. Empirical estimates suggest that a moderate tax on health care to fund health care for the needy would not cause substantial changes in individual behavior. Estimates from the literature on the tax subsidy to health insurance premiums suggest that entirely removing that subsidy would reduce national health spending by only 5 to 10 percent. This relatively low level of responsiveness suggests that a tax on health spending would not greatly distort national health spending decisions at any given time. Furthermore, the tax rate would be held constant at a low level and, unlike other kinds of taxes used to fund health care, would not increase with increases in health costs. Any distortionary impact of the tax would not increase over time.

11. This 60 percent figure reflects differences in the level of health of the insured and uninsured populations and is based on an estimate that overall spending by the uninsured would increase by 57 percent if they received an average-quality health insurance package (OTA 1994). Actual spending by the uninsured is closer to 50 percent of average spending, because the uninsured tend to be younger and healthier than average.

12. The tax rate needed to correct for the externality is $x \cdot y/(1-y)$, where x is the relative size of the minimally adequate bundle (e.g., 60 percent) and y is the proportion of the population of concern (e.g., ⅓). If the minimally adequate bundle were defined at 50 percent of the average and the population of concern was the bottom ¼ of the population, the tax rate would be only 17 percent.

13. Approximately half of all seniors have incomes below two times the poverty line (DHHS 1995). Note that this calculation assumes that coverage for the Medicare elderly would continue at the current level, rather than at 60 percent of the average level.

14. The tax would have to fund $115 billion in Medicaid expenditures and about $42 billion in spending for the 23 million uninsured with incomes below twice the poverty level, assuming that average spending by the uninsured

would be equal to average spending by low-income adults in the Medicaid program (DHHS 1995).

15. The availability of private insurance for services in the private sector might lead to an increased call on public-sector resources (as is the case for Medicare supplemental coverage). This increased usage would be relatively small, because the public sector in a single-payer system does not require co-payments and deductibles. It might, however, be appropriate to add a further tax on private health insurance coverage.

16. This calculation assumes initial spending of $4,000 per capita, 3 percent per capita spending growth in the tax-financed system, and 6 percent per capita spending growth in the private system. My analysis assumes that the private sector provides supplemental care and does not divert care from the public sector. If the private sector diverted care from the public sector, per capita spending in the public sector would grow faster.

References

Abbreviations

AEI	American Enterprise Institute
AHA	American Hospital Association
AMA	American Medical Association
BNA	Bureau of National Affairs
CBO	Congressional Budget Office
CEA	Council of Economic Advisers
CRS	Congressional Research Service
DHHS	Department of Health and Human Services
EBRI	Employee Benefits Research Institute
GAO	General Accounting Office
GHAA	Group Health Association of America
HCFR	*Health Care Financing Review*
HIAA	Health Insurance Association of America
JAMA	*Journal of the American Medical Association*
JAVMA	*Journal of the American Veterinary Medicine Association*
NBER	National Bureau of Economic Research
NEJM	*New England Journal of Medicine*
OECD	Organization for Economic Cooperation and Development
OMB	Office of Management and Budget
OTA	Office of Technology Assessment
PROPAC	Prospective Payment Assessment Commission

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