

Critical Error: Tom Daschle's Blurred Health Care Vision

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Tom Daschle's new book, *Critical: What Can We Do About the Health-Care Crisis*, confirms that advocates for a complete government takeover of American health care have learned an important lesson: Don't try it in one big bite. Here Daschle and co-author Jeanne Lambrew have direct experience. Mr. Daschle was a Democratic leader in the Senate during the push for "HillaryCare" in the first Clinton administration, and Ms. Lambrew toiled as a health policy analyst in the White House during the second Clinton term. Now President-elect Barack Obama has chosen Daschle for Secretary of Health and Human Services and Director of the White House Office of Health Reform, while professor Lambrew will serve as Deputy Director.

Starting with President Truman, *Critical* gives a brief account of American health care and the challenges faced by proposals for a national health system. Daschle and Lambrew note with dismay that doctors have been prominent opponents of a national plan, fearing it would inhibit individuals' choice of physicians, and certainly the autonomy of physicians themselves. Most doctors still resist a government takeover and so do other groups. *Critical* dismisses their concerns. The "we," who will "do" something about the "health-care crisis" refers to Daschle and Lambrew, not the small-business advocates, unions, American families, or anyone else who would suffer the diminishing choices and innovation in America's health care sector, should a national health plan materialize.

Nationalized health care has faced competing ideas, and that frustrates Daschle and Lambrew. They lament the days of the Clintons, when the question was *how*, not *whether*, "we" would find a way to implement a national health care program. Luckily for them, the flame of government-monopoly health care flickered in key states. Governors Romney of Massachusetts and Schwarzenegger of California, they point out, each attempted their own Clintonesque plans. Schwarzenegger failed and Massachusetts has suffered spiraling costs and poor access.¹

Daschle and Lambrew focus on the uninsured, noting that people are likely to switch jobs simply for employer-provided health benefits. Many are also afraid of starting their own businesses, because their health insurance is tied to employment. At the same time, more firms are unable to pay increasingly expensive premiums. Daschle and Lambrew also cite the problem of the young "invincibles" who do not want to pay for health insurance, and those with pre-existing conditions who must pay more for coverage than healthy people. Unfortunately, Daschle and Lambrew fail to indict the tax policy that forces us into employer-based plans as the primary cause of uninsurance, and fragmented, uneven access to health benefits. This may be because their new boss's opponent, Senator John McCain, identified the problem and proposed an effective solution for it during the campaign.²

Advocates of a nationalized system charge that health care in the United States is inadequate compared to nations with such systems. Daschle borrows these arguments, quoting statistics on infant mortality in the U.S. compared to other countries, despite inconsistent methods of measurement. He also quotes statistics on surviving various kinds of cancer in the U.S. compared to Canada and Australia, which he claims reflects the "sporadic quality of care in the U.S." Daschle and Lambrew remain willfully uninformed of research that challenges these conclusions.³

They do grant that the United States excels in breast-cancer survival and adequate preventive care including pap tests and mammograms. They also acknowledge that the U.S. has some of the world's best specialists and medical training that attracts the most talented physicians from all over the world. There is no question that freedom to innovate and compete underlies the American reputation for highly specialized and advanced medical procedures and drugs. This reputation continues despite the most diverse population in the world, with equally diverse health needs.

Increasing regulation of the health industry, by way of comprehensive and weighty government overhaul, would dramatically reduce opportunities for innovation and competition here. Nevertheless, although they recount unsuccessful proposals for national health care in Congress, Daschle and Lambrew argue that we must replace our disorganized, two-tiered system with “universal” health insurance, and a new government entity called the Federal Health Board. This body would make decisions about the cost of care and the appropriate benefits offered by the national health plan, while somehow being magically insulated from political pressures.

The *Critical* authors approve of Britain’s National Institute for Health and Clinical Excellence (NICE), which provides guidance on new medical procedures and drugs for the National Health Service (NHS), thereby reducing the amount of care available to citizens in order to keep costs down. In a strange but unique insight, they compare their health board to the U.S. Federal Reserve Board, forgetting that the Fed manages only one thing – the dollar. The Fed as an example of an effective government monopoly might surprise those suffering through the current economy.

Daschle and Lambrew’s goal is drastically to extend and build upon the government health programs we already have. They would expand the Federal Employee Health Benefits Program (FEHBP) which would “guarantee” a basic set of health insurance benefits to everyone who does not have employment-based insurance. They would also have, alongside the expanded FEHBP, another government-run insurance program modeled after Medicare, into which many working-age people could opt. Finally, they would expand Medicaid, another government welfare program.

Daschle and Lambrew not only promise that these expanded government programs would cover every single American, but also promise to extend the benefits to cover more mental health care, long-term care, and dental care. They justify this with the rationale that expanding coverage will automatically trim costs by cutting waste which contributes to unnecessarily rising expenses. While easy for the authors to write, that will prove exceedingly difficult for a federal bureaucracy to execute.

The Federal Health Board would set rules for the FEHBP, help design a Medicare-type insurance plan to compete with private insurers, and recommend research priorities and “high value” care by promoting coverage of particular drugs and procedures. While the Board’s recommendations would “have teeth” because all the federal health programs would have to follow them, it should not be considered a regulatory program. Instead, they claim this sprawling government model would simply serve as an example for private insurers. Daschle and Lambrew conveniently ignore the role of Medicare and Medicaid in the destruction of private

health care by distorting providers’ actions and causing them to shift costs to private patients.⁴

They also argue that the alternative vision, that we should liberate individuals to shop for health benefits on their own, is not realistic. People enrolled in consumer-directed plans are becoming “angry voters.” Even though they are more cost-conscious – a very important part of improving our health system – Daschle and Lambrew report that consumers detest high deductibles and high co-payments. What the *Critical* authors do not acknowledge is that Health Savings Account-eligible, consumer-driven plans have been growing in popularity and are increasingly being tailored to appeal to a wider audience – and government regulations *prevent* them from being more attractive.⁵

They also gloss over the reality that “insuring” every American with a sweeping health plan will invariably increase expenses in the form of higher taxes, causing a huge drag on Americans’ welfare.⁶ What we really need is to decrease health care costs for individual Americans, so they can choose to buy health care, and/or health insurance coverage that best suits their individual needs. Doing this effectively will require detaching insurance from employment altogether, and deregulating some of the existing government mandates, which Daschle and Lambrew adequately describe: State taxes on insurance premiums and mandates that require policies to include services have greatly increased the cost of health care in this country.⁷

Daschle and Lambrew perform rhetorical somersaults to avoid depicting their proposal as a completion of the government takeover of American health care, which began four decades ago. Instead, they pitch it as a “strong public framework for a high-performing, private system.” Unfortunately, such a public framework for health plans on a grand, national scale would strangle competitive enterprise in health care. Despite noble efforts to insure every single American citizen, *and* reduce health costs, *and* increase the quality of care, top-down government regulations are simply ill-equipped to achieve these goals in an effective, sustainable way.

The first eight years of the 21st century were a period of very tentative reforms on the national level to return dollars to American families to spend on the health care they prefer, instead of that which the government or their employers prefer. Americans might look on those small reforms as the high-water mark of consumer-driven health care in this country, if Mr. Daschle and Ms. Lambrew are able to execute the vision they portray in their book.

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Endnotes

- ¹ John R. Graham, "New York Times' Funny Math on Massachusetts Health Care," blog entry (San Francisco, CA: Pacific Research Institute), August 30, 2008, <http://liberty.pacificresearch.org/blog/sid.new-york-times-funny-math-on-massachusetts-health-care>.
 - ² John R. Graham, *Presidential Prescriptions: Diagnosing the Candidates' Health Reforms* (San Francisco, CA: Pacific Research Institute, October 2008).
 - ³ See, for example: Robert L. Ohsfeldt and John E. Schneider, *The Business of Health: The Role of Competition, Markets, and Regulation* (Washington, DC: The AEI Press, 2006); John C. Goodman, Gerald L. Musgrave, and Devon M. Herrick, *Lives At Risk: Single-Payer National Health Insurance Around the World* (Lanham, MD: Rowman & Littlefield, 2004); and Michael D. Tanner, *The Grass Is Not Always Greener: A Look at National Health Care Systems Around the World*, Policy Analysis No. 613 (Washington, DC: The Cato Institute, March 18, 2008).
 - ⁴ For a discussion of this cost-shifting, see John R. Graham, *California Health Care Deforminator: Model ABX1 1* (San Francisco, CA: Pacific Research Institute, January 2008).
 - ⁵ Diana M. Ernst, "2008: Next Steps for Health Savings Accounts," *Health Policy Prescriptions*, Vol. 6, No. 1 (January 2008).
 - ⁶ Jason Clemens and Adam Frey, "Understanding the Tax Implications of Single-Payer Health Care," *Health Policy Prescriptions*, Vol. 6, No. 9 (September 2008).
 - ⁷ For a discussion of mandates, see John R. Graham, *From Heart Transplants to Hairpieces: The Questionable Benefits of State Benefit Mandates for Health Insurance* (San Francisco, CA: Pacific Research Institute, July 2008).
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