

August 15, 2007

**COMMENTARY**

**DOW JONES REPRINTS**

## **Cost Control for Dummies**

By **MERRILL MATTHEWS**

August 15, 2007; Page A12

Reducing health-care spending isn't hard: Just give the government control over the national health-care budget and you'll see spending decline. Access to physicians and hospitals, the newest technology, important therapies and the best medications will also decline over time. But that's the trade-off society makes when the government controls health-care spending.

It's remarkable how gullible people are who claim, "Canada (or England, or France, etc.) manages to provide universal coverage for much less than the U.S. spends on health care." They seem to think these other countries have reached some sort of economic nirvana. These countries spend less -- usually between 8% to 10% of GDP versus nearly 16% in the U.S. -- simply because health-care spending isn't a function of consumer demand; it's a function of political demand.

Politicians in single-payer countries -- where the public pays higher taxes and the government pays most bills -- decide how much the country will spend on health care, and the prices that will be paid. Since they have to consider education, welfare, defense, etc., as well as the need to keep taxes low enough to encourage economic growth, there is never enough money to go around. There is not one government-run health-care system that is considered adequately funded by those who have to deal with it. In some countries, the rationing, lack of access and waiting lines are worse than others. But they all face these problems.

And virtually any U.S. reform proposal promising "universal coverage" will do the same thing. Why? Because Congress has a long and sordid history of support for health-care price controls.

Medicare reimbursements to hospitals have been price-controlled since 1983, and to physicians since 1992. If Medicare represented 1% or 2% of the health care market -- as the VA does with respect to prescription drugs -- price controls would create distortions, but they would likely be manageable. However, Medicare is the *dominant* insurer in the country. Its price controls become the benchmark.

Whenever the government controls prices, it arbitrarily determines who it will pay, how much, and for what. Vendors -- that is, providers of goods and services -- generally begin to work the system in order to maximize their gain -- or, more accurately when referring to doctors in Medicare, minimize their losses. When Medicare distorts a price -- and virtually all government-set prices are distorted -- the reverberations are felt throughout the health-care system.

Consider physician reimbursements. Every year, doctors face a *cut* in Medicare reimbursements, even though their costs for providing care continue to rise. The American Medical Association's lobbying effort has managed to keep current reimbursements about the same as they were in 2001, in part by backing the Medicare Modernization Act in 2003. That's six years without an increase. And unless Congress acts, doctors face a 10% cut in reimbursements in 2008, and a 40% cut by 2016.

At this point, we don't know where doctors' Medicare reimbursements will land; that issue has become a political football in the battle over reauthorization of the State Children's Health Insurance Program (Schip). Democrats are dangling a slight increase in reimbursements, instead of that 10% cut, in exchange for the AMA's support for their massive expansion of Schip.

However, Democrats also want to cut reimbursements to health plans operating in the quickly growing Medicare Advantage program. And they are trying once again to give the federal government the ability to dictate prices -- which they inaccurately describe as a "negotiation" -- for prescription drugs.

All of this is being done in the name of "controlling costs." But does anyone really believe those price controls won't hurt access to quality care?

Increasingly, doctors are refusing to see new Medicare patients. A recent AMA survey found that 60% of responding doctors said they would stop accepting new Medicare patients if the 10% cut is imposed. Even if that figure is inflated by currently angry doctors, it could represent a significant decrease in seniors' access to care.

The situation is worse under Medicaid. It reimburses even less than Medicare, which will lead to more and more access problems for the elderly and the poor. It can also lead to doctors trying to see ever more patients in a given time period in order to keep the income from falling. Less time for each patient reduces the quality of care.

Because politicians want to keep health-care spending as low as possible, they have very little incentive to raise those reimbursement rates. Much easier to rail against "greedy physicians" or use them as pawns when they want to pass other pieces of legislation. You can expect even more political maneuvering if health-care "reform" gives the government increased control over prices and spending.

Either the market will set prices based on supply and demand, or the government will set prices based on budget priorities and bureaucrats' best guess at what specific goods and services should cost. That process may undermine the access to and quality of care, but at least government-run health care advocates can claim it keeps costs down.

***Mr. Matthews is director of the Council for Affordable Health Insurance and a resident scholar with the Institute for Policy Innovation.***

URL for this article: <http://online.wsj.com/article/SB118714325206398102.html>

Copyright 2007 Dow Jones & Company, Inc. All Rights Reserved