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The Soviet Unionization of Health Care

by David R. Henderson and Charles Hooper

Few of us relish paying for health care, but when we do, amazing things happen: Strangers listen to us and try to give us what we want. There's a simple economic rule that what we pay for, we control. Insurers, hospitals, doctors, nurses, and drug companies listen to us when their livelihood depends on it. The more you take the individual customer/patient out of the equation, the more power we individuals lose.

The "health-care reform" currently touted by Beltway Democrats would take a system that insulates patients from the true cost of their health care — and insulate them more. It's a scheme for spending even more of OPM (other people's money). The Soviet Union ran the granddaddy of such schemes, even putting the cradle-to-grave "right to health" in its constitution. If we are smart, we will learn from the Soviets' failed seventy-year experiment, which succeeded in putting people into early graves.

Take the individual out completely, as the defunct Soviet system did with all industries, and the individual becomes irrelevant. The Soviet government was the only purchaser that mattered and, consequently, the government, not consumers, told producers what to make. When the state tried setting quantity quotas for nails, factories produced lots of little, pin-like nails. When the state set quotas by weight, factories responded predictably and produced big, heavy nails.

Recently, the U.S. Preventative Services Task Force caused a firestorm by reversing its previous position and recommending against giving mammograms to certain classes of women. Their logic? Screening younger and older women is less "efficient," meaning that more mammograms will be needed to prevent each additional death in those groups compared to the "better" patients in the middle group. In other words, more women will die of breast cancer, but we can take solace in the knowledge that their deaths allowed us to uphold some arbitrary standard of efficiency.

If the government gets to decide our health-care future, then it will decide who gets a mammogram and, as happened in the Soviet Union, health care providers will pay attention to

the government, not to us. The recent Task Force decision was simply a shot across our bow. And, of course, the process for deciding who gets a mammogram and who doesn't will ultimately be just as political as military-base closures and the government's involvement in General Motors. Just look at how the Task Force quickly backtracked under political pressure.

If the government sets up health care so that other people pay for your care and you pay for theirs, that doesn't mean that you'll get great care for free. All it means is that you'll pay a zero price — and high taxes — for whatever the government decides to give you. That's a big difference, and that's where rationing comes in. Rationing is entirely consistent with and, in fact, required by government-provided health care because basic economics teaches us that the amount of health care people demand increases when prices to the consumer drop to zero. As government health-care budgets inevitably balloon, suppliers will be squeezed to "share in the pain" and "give something back." This will complete the tragedy and double the rationing efforts, as the amount supplied will decline in response to reduced payments. Economic theory will be confirmed and our society will have taken a great leap backward.

We shouldn't forget the dire results of the Soviets' 70-year "constitutional right to health" experiment.

With unsanitary conditions, drunken personnel, bed sheets stained from past patients' blood, a lack of medical supplies, and workers just pretending to work, Soviet hospitals were a hundred years behind their U.S counterparts. Russian economist Yuri Maltsev points out that according to official government records, 78 percent of all AIDS victims acquired the virus through dirty needles and HIV-tainted blood in state-run hospitals. Patients had to pay bribes to garner even minimal attention from medical personnel. Hospital bureaucrats withheld anesthesia from patients as a further means of collecting bribes. Some in the Russian Parliament estimated the infant mortality rate to be seven times that of the U.S. rate. Shockingly, fifty-seven percent of all Russian hospitals did not even have running hot water. Not surprisingly, the Soviets had a two-tier system: one for the common citizens and a much better one for the Nomenklatura — the bureaucrats and party leaders.

It's true that these extreme examples are from the poor and backwards Soviet Union. It's not likely to get that bad here. But the principle is the same whether in the Soviet Union, Britain, or Canada: When the government pays, the government is the customer and the patient suffers. Take, for example, the waiting lists for medical care in Canada. Canada's Fraser Institute, which publishes an annual report on waiting times, estimates that the median waiting time between referral by a general practitioner and an appointment with a specialist was 8.2 weeks in 2009. The median time between the appointment with a specialist and an actual medical procedure was 8 weeks. The total wait: over 16 weeks or almost four months.

Consider admissions to the E.R. In American emergency rooms, the average wait before a patient sees a doctor is 30 minutes, according to *Reason* science correspondent Ronald Bailey. A

year ago, the British government set a maximum *target* of "only" four hours for the National Health Service. *The Guardian* reports that U.K. emergency rooms are meeting the four-hour goal through "patient stacking." Even seriously ill patients have been forced to wait outside in ambulances before they can be admitted, thus delaying the start of the four-hour timer — and tying up ambulances.

Moreover, European health-care systems, with the accompanying high tax rates, are one reason that Europeans' standard of living is 30 percent lower than ours. While this might seem unrelated, it is both germane and essential.

A private firm says to its customers: If you want this service or product, you'll have to pay for it. Under the Senate and House health-care bills, the government heavily subsidizes the insurance premiums of low-income people. As their income rises, the government reduces its subsidy. That means that people's implicit marginal tax rates — the amount of each additional dollar the government takes — rise. Harvard economist Greg Mankiw estimates that the reduction in subsidies adds an additional 23 to 32 percentage points to marginal tax rates for middle-income families. This amounts to a doubling of marginal tax rates to around 60 percent or so. Some smart taxpayers, looking at keeping only about 40 cents of an additional *reported* dollar of income, will respond by shifting their time to untaxable pursuits such as retirement, recreation, or the off-the-books economy. After all, why work for something you will receive anyway? Economists have a vivid term for these distorting effects of high marginal tax rates: deadweight loss.

In the frenzied sprint to further insulate Americans from their health-care costs and to spend OPM, most Americans will be the big losers. Genuine reform should move us as far away from the Soviet disaster as possible. ObamaCare is, at best, a distraction and, at worst, multiple hops down a dreary path that history admonishes us to avoid.

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