

The FPSTI v. Socialized Healthcare: A Quantal Comparison

DIAGNOSIS:

Let's look at the characteristics that define two different systems for facilitating the health of a nation's citizenry. In assessing the vast assortment of alternatives, there are various questions we can ask: Which system is most efficient (i.e. yields the best results for the most people for the lowest cost)? Which system is more moral? Which system makes the general populace the healthiest? Which system leaves people out in the cold?

By assessing the alternatives at our disposal, we can answer these questions. Here, we will find the answers by modeling the two archetypical systems for delivering healthcare to the citizens of the United States. Thus, I will describe two archetypes, understanding that there are myriad gradations between the two. The comparison of archetypes will help illustrate the point at hand.

Here in the U.S., it's been explicitly stipulated that a *raison d'être* of the State is to "promote the general welfare". This is clearly specified in the U.S. Constitution's preamble. "To form a more perfect union", then, entails providing the means by which the welfare of The People can be secured. Part of this "welfare", it would seem, is the health of each person.

The two basic alternatives for accomplishing this, as archetypes:

A: A FPSTI

(A for-profit, sickness-treatment industry is the system we currently have in place.)

B: Universal public healthcare provided by the State

(Here, the provision of healthcare is socialized.)

A is primarily a private-sector approach while **B** is primarily a public-sector approach. Each involves roles for BOTH the private and public sectors. Each entails a different allocation of society's resources (i.e. money, focus, time, energy) in order to accomplish the same goal.

A is generally about maximizing the amount of money people will pay in order to be treated—as it is a business model. Here, maximization of profit (for the business) is the sumum bonum. The motivation derives from: There is money to be made off of sickness. Treatment, then, is mostly RE-active, and is seen as a consumer product. The civilian, meanwhile, is seen as a (target) customer.

In this scheme, who is served? Only customers willing and able to pay the market price. Cui bono? The primary beneficiaries are:

First: The companies that profit off of sickness or the companies that charge the most for coverage while covering the least amount.

Second: To varying degrees, those with the financial wherewithal to pay for the products and services hawked and sold by those companies.

By contrast, **B** is about maximizing the health of the general populace, making everyone a part of the solution—regardless of socio-economic position. Scheme B is predicated on a “we’re all in this together” approach. In this scheme, healthcare is a public service. Here, the maximization of well-being (for everyone) is the sumum bonum. The motivation derives from: There are lives to be saved from sickness, and sickness to be avoided if possible. Who is served? Everyone. Cui bono? Everyone.

The contrast between the motives involved in each system is a stark one.

Both **A** and **B** involve the majority of people in society somehow investing—directly or indirectly—their money into the system at hand. That is: Both schemes are ways of using THE PUBLIC’S money to provide medical services to various people. The relevant questions to pose, then, are:

Which system is most efficient overall?

Which system is most effective for the most people?

(We posit as an axiom that all civilians “matter” the same amount. Our evaluation is predicated on this assumption.)

MODELING EACH SYSTEM:

All facets of each system will be assigned a variable: a thru z.

With **scheme A**, everyone’s money is channeled through A1, A2 and A3 to the ultimate destinations: A4 and A5.

A1 On a case-by-case basis, direct payment is made to A4 (a) and to A5 (b). This is for those with financial means who opt not to partake in A2.

...or...

A2 Insurance companies are used as a conduit. The price involved is accounted for by the companies' profits (c), lawyers / litigation (d), operating costs (including bureaucracy, overhead, salaries / wages to employees / laborers, etc.) (e), paying lobbies (f), and sales/marketing campaigns (g). In addition to these expenses, there are the payments made to A4 and A5 (h).

A2 is done either via privately-purchased health insurance coverage or via employer-provided health insurance coverage. In the former case, the payment from the civilian is direct. In the latter case, it is done in the form of compensation ("benefits") from an employer. Either way, it is money out of the civilian's and/or the employer's pockets.

...Meanwhile...

A3 Everyone has to pay taxes to the government, which funds the V.A. (i), Medicare (j) and Medicaid (k).

(A1, A2, and A3 are routing mechanisms through which both A4 and A5 are paid.)

A4 Payment to private (for-profit) medical equipment manufacturers and Big Pharma. For each, the amount is accounted for by profits (which often includes the bloated executive pay-packages) (l), paying lobbies (m), lawyers / litigation (n), marketing campaigns (o), and massive sales forces (p). In addition, there is the portion of R & D costs not subsidized by the NIH (overhead, salaries / wages of employees / laborers, MRO, etc.) (q). All of these elements go into the prices that are charged.

A5 Payment to private (for-profit) hospitals and for-profit private practitioners. In both cases, this includes profits (r), liability insurance (s), marketing (t), and regular operating costs (overhead, employee pay, etc.) (u).

In this scheme, A4 and A5 can "jack up" their prices due to power asymmetries and information asymmetries, as well as due to monopoly power over a given area.

NOTE:

In order to simplify the tabulations, several things can be consolidated under Medicare (j) and Medicaid (k). Therefore, let the values for (j) and (k) include not only the amounts used directly under those systems, but also any/all subsidies the government must pay on behalf of those with insufficient means for private medical insurance. We can also include in (j) and (k) the total amount of the federal budget devoted to social security checks that ends up being spent by the recipients on medical costs. Moreover, we can add to THAT amount the money that is used for food stamps to help people that otherwise may not need the assistance had they not have to worry about medical bills. Lastly, we can include here the entire budget of the NIH.

While saving letters of the alphabet used for variables under scheme A, we should note that j and k—when adding all this together—are GIGANTIC...and that NONE of this exists in scheme B.

Also keep in mind that l, m, n, o, and p include the amount of money used (for each) by ALL Pharma AND ALL equipment manufacturers COMBINED. This sum accounts for a huge portion of the total cost of scheme A...costs that don't exist in scheme B. Moreover, r, s, and t account for a massive amount as well...costs that don't exist in scheme B.

Finally, note that c, d, e, f, and g don't go to A4 or A5 because it is all siphoned off in the process. In other words, c, d, e, f, and g are wasted in Scheme A...something that doesn't happen in scheme B (which, we'll see, uses every penny put into the system, in some way, to fund healthcare services).

With **scheme B**, peoples' money is channeled through B1 to B2 and B3.

B1 Taxes to the government, which fund B2 and B3.

Unlike in scheme A, these funds are not needed for Medicare (i) or for Medicaid (j)—as these things no longer exist. However, unlike in scheme A, the government now has to cover the cost of provision (upkeep of all facilities, administration, overhead, reasonable salaries / wages for all practitioners / laborers, etc.) (v). This is in addition to payments to medical device manufacturers and Pharma (w), which would not merely be the limited subsidies provided in scheme A (through NIH), but would have to cover the ENTIRE cost. Why? Because in scheme A, much of the cost is paid by insurance companies and/or comes straight out of the civilian's pocket. (B1 is the analogue of A3.)

B2Provision of service (by the State) to the general populace.This includes ONLY THE COST of operation (MRO of facilities, compensation of employees, etc.) (x).B2 is non-profit—since it is a public service, not a business—and thus operates only at cost.Meanwhile, the State requires no liability insurance.(B2 is the analogue of A5.)

(We assume here that B2 is executed competently—such that everyone has equal, convenient access to high-quality services.)

B3Covering the operating cost (overhead, salaries and wages, etc.) incurred (via R&D) by both private (for-profit) medical equipment manufacturers and Pharma (y).This is in addition to covering MODEST profits (kept in check by monopsonistic negotiations) for each type of business (z).(In other words, B2 is the total payment—made by the government—to all private industry for equipment and drugs used by the public healthcare system.)

Prices charged in B3 are lower than in scheme A because there is no budget for marketing, or for the massive sales forces, or for lobbying, or for lawyers, or for exorbitant salaries and obscene profits.(We assume that “lobbying” for government contracts would not be so significant as to be a major business expense.)In scheme B, none of the aforesaid expenses need be accounted for by such businesses, as their target customer is no longer the general populace.(B3 is the analogue of A4: same institutions, lower costs involved...meaning lower prices for the buyer.In scheme B, the only buyer is the government.)

(Analogues of A1 and A2 don’t exist in scheme B.)

In this scheme, B3 (unlike A4) cannot jack up prices, as power / information asymmetries don’t exist, nor does monopoly power.(This is because the “customer” is a monopsony: the government is the omni-buyer.)Here, the NIH subsidizes EVERYTHING in the private sector, and has absolute bargaining power—which ensures no abuse of funds occurs (e.g. exorbitant pay-outs to executives and stockholders).

Moreover, the prices paid to Pharma and equipment manufacturers in scheme B ($w = y + z$) is much less than the prices paid in scheme A (h).Why?Other than the fact that (w) doesn’t have to account for m, n, o, or p, the profit for such companies would be less in scheme B ($z < l$).We assume that the operating costs for such companies would be roughly the same in both schemes.



For scheme B, not only does insurance coverage not exist for the general populace, there is no liability insurance that practitioners (i.e. service providers) need to pay for—as they are public employees.

PROGNOSIS:

For scheme A to work, the following is required:

$$A1 + [A2 - (c+d+e+f+g)] + (A3 - i) = A4 + A5$$

Again, note that c, d, e, f, and g don't go to A4 or A5 because it is all siphoned off in the process. Meanwhile, (i) doesn't go to A4 or A5 because it goes toward socialized healthcare for veterans. Thus, c, d, e, f, and g are wasted, while (i) is used in the way that it would be used in scheme B.

For scheme B to work, the following is required:

$$B1 = B2 + B3$$

In either scheme, this is simply about balancing what is paid into the system with the costs of the system.

There are two important questions to be asked:

Regarding input: Which scheme costs more? In other words: Which system requires more money to be put into it?

This can be answered by determining which is greater: $A1+A2+A3$ or $B1$? More specifically, which is greater: $a+b+c+d+e+f+g+h+i+j+k$ or $v+w$?

Another way to ask this is: Is $A4+A5$ or $B2+B3$ greater? More specifically, which is greater: $l+m+n+o+p+q+r+s+t+u$ or $x+y+z$?

Here, we can note that, in scheme A, l, m, n, o, p, r, s, and t don't go directly toward providing medical services. Meanwhile, in scheme B, only (z) doesn't go directly toward providing medical services.

Lastly, it should be noted that in Scheme B, the overall amount spent on services will be less—since it will be servicing a healthier general populace.

Regarding outcomes: Which scheme has the best results (in terms of health of the general populace)? In other words: Which system has the most efficacy for the most people?

Regarding freedom: Which system inhibits the typical person's ability to CHOOSE his own physician?

In scheme A, all but the wealthiest people find that they are quite constrained. Most people are limited to the options dictated by HMOs and "Healthcare" providers (i.e. the insurance companies). Here, almost all decisions are mediated by insurance companies and by other business interests.

By stark contrast, in scheme B, anyone is free to use whatever facility that want, at any time, wherever they are in the U.S., whoever they may happen to be. Like the fire department or the police department, no matter who you are or where you are, the public service is there, at your disposal, whenever you may need it. Nobody "controls" your decisions. There is direct interaction between doctors and patients, without the intermediary of insurance companies and other business interests mediating the provision of care. Here, doctors AND patients have more freedom.

VERDICT:

Scheme A costs MUCH, MUCH more than scheme B. A2 is probably the biggest culprit in causing the colossal inefficiency of Scheme A. Insurance companies have every incentive to charge as much as possible, and every incentive to minimize service. (Insurance companies, we have found, are the epitome of bloated bureaucracy and conflict of interest.)

Meanwhile, in Scheme B, insurance companies don't exist.

Comparing A3 and B1 is complicated. We already know what A3 is. We can only make an educated guess as to what the difference in federal government outlays in the U.S. would be for B1.

A3 must fund Medicare, Medicaid and tens of thousands of bankruptcies... PLUS take care of a sicker population (re-active medicine)... whereas the budget in B1 doesn't need to worry about such things (because they will all be eliminated). However, B1 has the added role of funding all healthcare provisions for everyone in society.

In scheme A, there are tens of thousands of bankruptcies due to unwieldy medical bill burdens. In scheme B, no such problem can arise.

In B1, no responsible person ever pays a medical bill...ever.(Those culpable for avoidable ailments may have to pay part of the cost out of their own pockets.)Nor does anyone have to ever pay insurance companies...ever.ALL money will be used to fund healthcare provision for everyone: costs incurred by the non-profit public service provider (i.e. the State).

Scheme B yields FAR, FAR greater results.We need not speculate: This is clearly demonstrated in all places that already use a system resembling scheme B.Indicators of quality of life and general public health can be used as the barometer for making such comparisons.For outcomes, the U.S. currently doesn't make the top 20 nations, while it is the highest in the world for money put into the system.That is to say: Scheme A is the most expensive system in the world while not yielding even close to the best results.

How can this be explained?Unlike A5, B2 has every incentive to keep people as healthy as possible, thus—essentially—MINIMIZING “business”.Unlike A2, B2 has every incentive to treat all people who need to be treated.

Incentive to innovate is in no way compromised in scheme B, as is clearly demonstrated by real-world examples.It should be noted that there is a place for the private sector in scheme B.The system preserves private (for-profit) enterprise for R&D of drugs and medical equipment.Here, businesses compete in the marketplace for “business”—presumably, based sheerly on merit.Indeed, advancement in medical technology can transpire in the private sector (subsidized by the State, with well-enforced ROTA) even as PROVISION OF SERVICE takes place in the public sector.

Thus, scheme B preserves free enterprise precisely where it has virtues (serving as a vehicle for innovation), while eliminating it precisely where it is inappropriate (taking the place of something that—morally—should be treated as a public service).

In scheme B, there is no game where players strive to minimize coverage while maximizing revenue (i.e. cost to the public).In scheme B, there are no corporate executives and high-ranking salesmen making ridiculously obscene salaries...while tens of millions of people are left out in the cold.

Finally, in scheme B, a large amount of personal funds (from social security, from pensions, from private savings) will be freed up to devote to things OTHER than medical / drug bills.Moreover, businesses don't have to account for health-insurance-benefits in employees' compensation...freeing up part of the budget for more investment in the business and/or higher wages / salaries.

The difference between the final tallies is some amount (X). This is money that would stay in the pockets of civilians, and thus be used for things OTHER THAN scheme A. In other words, X represents money that would be SPENT IN THE ECONOMY, thus creating demand for other goods and services. Thus, not only will EVERYONE be taken care of in scheme B, and not only will 10's of millions be much healthier (and thus far more productive), but people will have more to spend in the marketplace on consumer products. So even the private sector does better!

Transitioning from scheme A to scheme B essentially entails eliminating everything from (a) thru (k) from the input to the system...except for (i). Then, (i)—no longer exclusively for veterans—would be grown approximately 1,000-fold. In other words, it would be rendered consolidated funding for a centrally-coordinated, integrated healthcare system for EVERYONE. Here, (i) would become B1. The V.A. would essentially become a public service for every civilian: an entitlement afforded to each person simply by dint of being a citizen.

The bottom line is this: Doctors and scientists should not operate as BUSINESSMEN. Patients should not be seen as CUSTOMERS. Healthcare should not be a CONSUMER PRODUCT. It is safe to say that the best system—whatever it may be—is not only the most efficient system, it's not only the system that keeps the general populace the healthiest, it's the system with the least endemic, systemic conflicts of interest.

We can ask ourselves: in any cost-benefit analysis: Are costs only financial costs, are benefits only financial benefits? Are there other kinds of costs and benefits that should be taken into account when assessing the legitimacy of a system? Is economic gain the ultimate barometer for legitimacy? Or are HUMAN costs and HUMAN benefits relevant factors in our ultimate balance sheet?

The conclusion can't be avoided: Any demand for a cost-effective AND moral system entails using scheme B over scheme A. The pre-amble to the U.S. Constitution demands such a system.