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Pareto, Marcos Pompeu
Boston University

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BOSTON UNIVERSITY
DEPARTMENT OF ECONOMICS

**THE HEALTH CARE CRISIS IN THE UNITED STATES: THE ISSUES AND PROPOSED
SOLUTIONS BY THE 2008 PRESIDENTIAL CANDIDATES**

MARCOS POMPEU PARETO

Boston University
Department of Economics
270 Bay State Road
Boston MA 02215 U.S.A.

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Abstract

The United States has state of the art technology and world renowned expertise in medical treatment, yet in terms of healthcare it shows a dramatically poor performance in relation to the other industrialized countries. This situation is surprising, since one would expect that a free market system run almost entirely by the private sector should show a much better performance.

This issue has reached the point of being one of the most important national concerns and the subject of serious political and economic arguments – not only regarding how the system should be improved, but also whether it should remain being run by the private sector under a free market approach or whether it should be run by the government and made accessible to the entire population. The first option is supported by the arguments that public initiatives often perform poorly and that free-market competition should prevail. Contrarily, the other side claims that the system is only nominally a free market, that empirical evidence shows it's not working as it should, and that other successful healthcare systems are mostly government operated.

As is stands, the health care issue acquired national importance and is presented as a major component of both presidential candidates programs, yet each favoring a different approach to improve accessibility and lower healthcare costs. Republican Senator McCain relies on improving the system by maintaining its current private enterprise, free market characteristics, while Democratic Senator Barack Obama favours providing universal coverage and lower costs through a higher government intervention in the system. This paper examines the approaches proposed by both candidates and analyses the potential impact their plans may have on the health care system. While the lack of more detailed implementation details makes difficult accessing the effective result of each policy, the comparative review of the alternative approaches presented in this paper will help the reader to to judge for him or herself which could be the more appropriate to upgrade the system and attain a higher performance level.

Introduction

The United States health care system is deemed by many to be behind the other industrialized countries, achieving poor results in spite of having access to state-of-the-art technology and world-renowned expertise. With 47 million uninsured individuals and a perpetually increasing price tag for health care coverage, there is little doubt the system has failed. This situation has brought the health care issue to become an important political issue, attaining prominence in the programs of the presidential candidates.

There is a general agreement that the system fails because not only does it not cover all citizens, but also because it is extremely expensive when compared to other countries, while concurrently achieving inferior results (WHO, 2007). The best systems, such as Italy, France and Japan, provide coverage to their entire population, are government operated and yet cost only a fraction of the amount (in terms of percentage of GDP) of the United States.

Aside from cost, accessibility is one of the biggest concerns in today's health care system: not only do the uninsured have to wait in much longer lines, but the quality of the health care they receive is often inferior with respect to their insured counterparts. Hence better accessibility to health care is of utmost importance in the improvement of the system. In addition to accessibility, equality to access is just as important, if not more: those insured directly or with employer sponsored health plans have easy access to virtually any facility they may need, while those that cannot afford insurance or are not insurable by having pre-conditions are left without any coverage – it is generally assumed that 47 million Americans do not have medical insurance. Since the latter are more likely to require treatment, the current system fosters the perverse irony in that those that least need it have an abundance of it, while those that need it most are often kept out. Consequently, for a significant improvement in general health, a form of universal health care is needed.

While there is widespread agreement of the gravity of the current conditions, there is much controversy as how to handle it: on one hand some think that the key to keep costs down and quality up is via the traditional market-oriented approach of increasing competition between insurance providers. Others, however, believe the a universal approach may be the only way to go, seeing that most, if not all, of the best health care systems in the world are primarily, if not entirely, government-oriented (WHO, 2007)

Currently the former approach being championed by Republican Senator John McCain, while the latter by Democratic Senator Barack Obama. This paper intends to shed some light on their programs on healthcare and estimate the potential impact they may have of the health care system in general, based on the literature provided.

The Health Care Issues in the USA and the Candidates' Proposed Solutions

While most people may agree that the current system has serious flaws, there is major disagreement as to how to approach the problem. Some have suggested increasing competition, while others decreasing it. Yet one thing is clear: in this tug-o-war of ideas, little has been done in recent decades to address the issue. Just like the metaphorical driver who can't choose between taking the right or left road ends up crashing in the middle, the current health care system is headed towards disaster should the status quo

continue.

While both candidates have significantly different approaches, they do share two common elements to achieve their goals. First of all, both candidates recognize the need to reduce the cost of health care, and secondly, both McCain and Obama plan on increasing accessibility to the general public.

Senator McCain

Senator John McCain (R-AZ) intends to deal with the health care issue as one would do with any other free-market; that is, limiting government intervention and allowing the market to adjust itself. For this, Senator McCain emphasizes three important items in his health care plan: personal responsibility, accessibility and competition. Combined, these aspects reflect his strategy to reduce costs, increase the accessibility, and improve the quality of services (McCain 2008).

Personal Responsibility

When Senator McCain speaks of personal responsibility as a cost-cutting measure, he refers to it on two levels: personal and industrial. On the personal level, Senator McCain believes that each individual should accept responsibility for themselves regarding health care: he strongly favours having more choice on insurance programs, and schemes to motivate, rather than force, people to adopt healthier life-styles. Consequently, a healthier life-style would lead to reduced demand of medical resources and, consequently, reduced prices.

To stimulate healthier life-styles, Senator McCain's Campaign focuses primarily on smoking and obesity. While smoking has long been tied to cancer as well as various adverse health effects, recently it has also been linked to infant mortality. According to a study by Sara Markowitz, not only is smoking highly correlated with SIDS, but anti-smoking regulations and price adjustment have a great impact on reduction of SIDS: a 10% increase in real cigarette prices, for instance, can reduce SIDS by 6.9-7.6 percent, while a 10% increase on taxes, reduces SIDS by 1.6-1.8 percent. Regulations on the workplace and such prove to be also fairly effective, although not at the same level (Markowitz, 2008).

Consequently, if increasingly restrictive anti-smoking policies are introduced, there should be a noticeable improvement on the health level of the population, in turn reducing the healthcare costs associated with smoking. These policies could be especially effective, considering that smokers are typically low-income and hence would derive the greatest marginal benefit by the reduction of smoking (both health-wise and financially) (Laaksonen, Rahkonen, Karvonen, & Lahelma, 2005).

The other health improvement objective of the Senator McCain program is preventing obesity and diabetes. With the promotion of more exercise, healthier food at the school cafeterias and other such health oriented alternatives, Senator McCain intends to curb obesity, which has been on the rise for the past several years, as well as diabetes. Women who are morbidly obese (those with BMI > 40), are seen to have significantly higher adverse births than non-obese women. As a matter of fact, obesity in itself shows characteristics of being an independent factor for birth problems, hence increased infant mortality (Kumari, 2001). Furthermore, those with gestational diabetes face compromised pregnancy, regardless of

level of obesity.

As with smoking, obesity can also be very costly – a 2002 research by CDC calculates the costs associated with diabetes ranging from \$51.5 Billion (using MEPS data) to \$78.5 Billion (using NHA data) (CDC, 2007). Consequently, there is also much potential not only in reducing infant mortality, but also in improving health and reducing costs.

What may make this particularly effective is that, like smoking, obesity disproportionately affects the lower-income strata. Thus, both these programs, if effective, not only would improve the health level of the poor, but also reduce the costs associated with the treatment of smoking and obesity related illnesses.

On the industrial level, costs are not associated with poor habits, but rather with medical errors or methods used to prevent such issues. As it currently stands, the medical staff gets paid for the services rendered regardless of the outcome. Therefore, if a medical error or ineffective treatment is made, the hospital still gets paid by insurance (or by the unfortunate individual). People often sue for medical malpractice. However, the money usually doesn't come directly from the hospital or doctors, but by medical malpractice insurance, thus further increasing healthcare costs.

By supporting the principle that poorly done procedures will not be paid by public insurers, Senator McCain expects health care providers to be more responsible for their own actions, to assure the payment of their services. On the other hand, they would still have to pay for medical malpractice. While the policy may alleviate Medicare and Medicaid from such financial burden, it would increase the burden on hospitals due to reduced income, while not avoiding the high financial liability related to medical malpractice. These increased costs, in turn, would likely end up being shifted to the public through increased insurance premiums (GAO, 2003).

Accessibility

Senator McCain realizes the accessibility issue and proposes to tackle it by creating walk-in clinics that would serve the general public while easing the demand pressure exerted on the hospital's emergency room. Such an approach would facilitate obtaining simple, preventive care. Currently, there are several walk-in clinics in the US, yet still considered to be too expensive to be affordable by the poor (\$20 and up per visit for basic check-up, \$50 or more for additional services) (RediClinic, 2007). If the patients were to pay directly for such medical treatment this program may prove to be largely ineffective, since only those with money would be able to afford the privilege, and consequently would have a low impact on health conditions. On the other hand, a reduction of cost to the users will require some form of subsidy. If this is the case, then it would indeed contribute significantly in increasing accessibility and improving the quality of care to those who currently cannot afford insurance. A visible risk is that the availability of a subsidy would probably contribute to inflate prices by increasing the demand for health care, thus reducing some of the benefits. Furthermore, only limited care can be provided by a clinic and the services than can be made available in a clinic cannot cope with more serious cases that require hospital treatment, for which a more complete insurance is needed.

Sen. McCain realizes that the funding of health care is also a major issue adversely affecting accessibility.

Currently, the costs of insuring a family are above \$12,000 (NCHC, 2008). He proposes to subsidize these costs by offering to pay \$2,500 per individual or \$5,000 per family, thus socializing a part of the personal health care burden. Such contribution would primarily benefit those bordering the threshold of affording private insurance. Without any financial assistance, they would remain uninsured, yet with financial assistance they would be able to purchase insurance and participate in the existing system. Those with resources already have insurance and their health care benefit would not be as significant. While this would improve significantly the accessibility to the current system, unless both health care costs and insurance costs are brought down significantly, quite a few families would still be under the affordability threshold and thus unable to join the system.

It is still unclear how unspent money could be used: if it must be deposited in a HSA, then there would be a direct health care benefit, however limited by the value on the account. On the other hand, if the money could be used freely, it is dubious whether it will be spent on either medical care or deposited into the HSA, especially given the current sub-prime mortgage problems, where those with low credit (again, typically the less affluent) are behind on their payments often facing an immediate risk of foreclosure.

Competition

This is one of Senator McCain's biggest differences from Senator Obama as a cost-cutting measure: while the Obama favors a more government oriented approach, Senator McCain favors a competitive, market-based approach. One would normally assume that competition is the best, if not the only way, to keep costs down and quality up. However, competition has different outcomes depending on the area of health care that is affected: the pharmaceutical industry works much like the traditional market, in that increased competition does favor increased quality at reduced prices. Ironically, however, the insurance industry does not work in the same way.

Unlike most markets, demand for health care can be highly variable and potentially extremely expensive. On one year, for example, person X could be in excellent health, while the next year he could get into a car accident and spend several months in the hospital costing the insurance company hundreds of thousands of dollars. Consequently, a person is not – and cannot – be seen as a source of profit, but rather as a potential liability. Given the right to choose clients, the industry in fact shifted their market position – it is not the health insurers that compete for the clients, but rather the clients are the ones that must compete to buy insurance from the insurer system, which behaves as an oligopoly. Although basically run by the private sector, the healthcare system can hardly be considered a to follow the free-market model, which is characterized by buyers choosing the sellers and not the other way around.

As it is, insurance institutions are especially careful in choosing – and keeping – their clients: since picking the wrong ones could potentially be financially devastating. Also known as adverse selection, it, in turn, leads to “cream skimming”, where they purposefully choose the “cream of the crop” clients, or “dumping”, where they dump the more costly clients (Ellis, 1998). In a twisted sense of irony, insurance providers systematically pick the healthy and dump the sick.

Furthermore, when profits from high-risk individuals are negative, Pareto improvements can be implemented, such that the increased benefit of one group does not decrease the benefits of other groups

(Olivella & Vera-Hernandez, 2007; Vaithianathan: Health insurance and imperfect competition in the health care market, 2006). This further demonstrates the ineffectiveness of the current circumstances and the impossibility of introducing competition while the sellers can pick the clients and dictate the rules. Due to these issues, true insurance competition cannot functionally exist.

What would happen, then, if Senator McCain were to open up state barriers and allow “full power” competition among insurance companies? As it turns out, the results could be much worse than one may think. Since individuals will naturally try to minimize their costs, those with questionable health will tend to purchase from states with communal rating based costs. On the other hand, the healthy will choose providers from less regulated states. This, in turn, may create a fragmented system in which the sick would conglomerate on certain states, while the healthy on others. The states with higher rates of high-risk individuals, would consequently resort to either 1) raising the premiums, which would push out those that could have barely afforded it in the first place; 2) relocate to a less-regulated state, although this is unlikely due to the costs of relocation; or 3) accept the increased costs and possibly declare bankruptcy (Collins & Kriss, 2008).

Such a fragmented, state-based system is unlikely to be economically sustainable and effective in keeping costs down or promoting equality. The problem continues to be how to keep allowing the poor to be able to pay for insurance: if nothing is done, then the poor would be back to square one, in that they the costs would force them back to being uninsured and health care inequality would be back to the way it is today, although, perhaps, a bit better. To deal with such issue the government would have to step in to regulate the market, which is very unlikely due to Senator McCain’s firm stand against government intervention.

This is evidenced under Senator McCain’s plan to cut the tax benefits of employer-sponsored health insurance. The removal of the tax cut would make sponsoring health insurance much more expensive and consequently - unless obligated to - employer sponsored insurance will eventually be dropped, pushing out workers to personally finance their own health insurance. Unless health care costs drop significantly, employees may not be able to keep up with the increasing costs and end up uninsured (Michaels, AFL-CIO Weblog | McCain's Health Care Plan: Higher Taxes, Less Coverage, 2008). Under these circumstances, equality of care will drop, in that only the rich would continue to be able to afford insurance, adversely affecting the poor and, eventually, the middle class alike.

Therefore, if competition were to work under the current inverted-market system it would be necessary for each person to be considered a source of profit, rather than a potential liability, as was already discussed. Only in such condition would insurers reliably compete with each other for business.

However, such a feat is impossible because there the main issue is exactly how to treat those that cannot afford the system or are dropped from it. By definition they cannot generate profit to the private sector providers and therefore would have to be covered by an alternative, non-profit oriented system, funded by the society as a whole. Such context makes the intended competition unachievable and thus insufficient by itself to help curb costs, while providing little help for the uninsured.

On the other hand, competition amongst pharmaceutical companies, behaves more in line to the traditional market, and therefore would be effective in lowering prices.

Consequently, whether or not his plan will ultimately exacerbate or ameliorate the situation is hard to tell: as it stands, it is hard to imagine a worse scenario, but that does not mean it can't happen. If Senator McCain truly wants everybody to have insurance, should they want it (government operated universal coverage is a big no-no), then he will have to continuously create health vouchers, which would inevitably result in inflating costs, increasing public participation and the consequent tax increase – exactly what he wants to avoid.

Conclusion

Several aspects of Senator McCain's plan hold promise. His intention is to follow the traditional market-oriented approach and let the people decide from themselves. Yet ultimately the main objective of improving health care while keeping costs down is not properly addressed – mostly because his concept of competition does not allow for this to happen. Ironically, his competitive approach will almost certainly counter the benefits of his health programs, and hence exacerbate the general health situation.

However, should he find a way to make all individuals insurable (Glazer & McGuire, 2000) and reduce the cost of health care by opening the market to effective competition, then it is likely that insurance providers would react in a more traditional manner.

Senator Obama

Senator Barrack Obama (D-IL) proposes a different approach in tackling today's health care problems. Unlike Senator McCain, who favors a market-driven approach under virtually every aspect of the reform, Senator Obama takes a government-oriented approach when there seems to be some form of market failure.

Like McCain, Obama's plan focuses on three different areas: supporting IT as a way to reduce costs, using competition as the means to decrease price while maintaining quality, and guaranteed access to all (Obama Campaign, 2007). While at first it may seem that Senator Obama's plan is very similar to Senator McCain's, they have important differences, as described below.

Modernization of IT

Modernization in health care could mean many things, each one with a potentially drastic effect on the quality and price of health care. For example, relying on state-of-the-art technology is one of the reasons why health care is so expensive (Beever & Karbe, 2003). Therefore, while increased technology may give better care, the cost associated with such care can be extraordinarily high, often costing thousands of dollars just to use a machine once. In such sense one could argue that American medicine is "too modern" (financially speaking, at least). Interestingly enough, Europe does not use as intensively hi-tech machinery as the United States, yet manages to keep a significantly healthier population with longer life-spans (World Health Organization, 2007) while keeping treatment costs down. While the use of such equipment may extend individual lifespans, its use is relatively limited, thus making any difference statistically insignificant on life expectancy rates. As such, it does seem that "excessive" technology can have an overly large cost-benefit ratio and that controlling their use may not necessarily be bad in terms of decreasing medical quality.

Yet this is not the only aspect of modernization that Senator Obama talks about. He also proposes to modernize the procedures of providing health - that is, rather than investing in more hi-tech machinery, he proposes to encourage more developed medical information databases that would be better linked to the various players in the health care system, as well as electronically file all patient records, as opposed to pen-and-paper still being used now (Obama Campaign, 2007).

This method of modernization is not only much cheaper to implement, but also relatively inexpensive to maintain. Based on the experience of its extensive and efficient use on other industries, from finance to law-enforcement to aviation, information management can significantly reduce operational costs while increasing efficiency. This initiative is especially important as it allows quick and easy communication between providers and insurers as well as the various members of staff, resulting in reduced waiting time (which in itself is very costly) and less medical errors. According to a study conducted by RAND, such modernization could potentially save \$77 billion dollars annually in reduced in-patient stays and medical errors (Giroso, Meili, & Scoville, 2005), which is more than enough to cover Senator Obama's \$10 Billion dollar investment proposal for such modernization strategy.

Furthermore, Senator Obama proposes to update the health care infrastructure. In addition to modernizing buildings, he also plans on creating a tele-medicine "structure" similar to Senator McCain's, allowing everybody, regardless of how inaccessible they can be from a hospital or doctor, to receive some basic medical assistance on-line. Such initiative would provide some more accessibility, yet it is hard to predict its effects, especially if it would affect significantly the less favoured segment of the population.

Modernizing hospitals would likely be extremely expensive and it is difficult to assess a cost-benefit ratio without further information. Altogether those are interesting ideas, yet at present one cannot appraise the real effects of such initiatives without more details on the extent that they would be implemented..

Finally, one point that may be of some importance is the simplification of the paperwork necessary to buy insurance. Currently, several eligible families do not have insurance because the paperwork is often confusing, bureaucratic and overly complicated (Sommers, 2006). This complication constrains some parents (and even more importantly, the mothers) obtaining health insurance and with them, their children.

Competition

Like Senator McCain, Senator Obama also favours increased competition. Likewise, we should analyse his policies on insurance competition separately from pharmaceutical competition.

A. Insurance

Unlike Senator McCain, who has been vocal about fostering competition amongst insurers as a way to lower costs, Obama has been relatively tacit in such matter. In fact, rather than expressly mentioning competition as the main method for price-adjustment, his plans rely on government intervention to set prices.

Such regulations that are proposed to lower insurance costs can be dubious. Senator Obama proposes to

constrain insurance companies from raising costs without justification. However, justification is an extremely subjective terminology, which may (or may not) constrain price variations that would have otherwise been market optimal. Furthermore, it is not specified what kind of justification would be needed: the insurance company, as any other company or entity in the country, seeks to maximise profits and increase revenue. Would that, then, be considered a good justification? Or what about if the justification were to be that they need additional funding to better serve the people?

It seems, at least at a first glance, that this aspect of his policy was designed to prevent corporate abuse, yet it may very well prove to be quite ineffective, primarily due to the arbitrary nature of the term “justification”. Should a company desire to raise prices, all they would have to do, then, is to come up with a “good” (read politically correct) reason to do so.

Secondly, Senator Obama would “force insurers to pay out a reasonable share of their premiums for patient care instead of keeping exorbitant amounts for profits and administration” (Obama Campaign, 2007). As before, the term “reasonable” is highly subjective and opens the door to human-error in judgement and abuse not unlike in the case preciously mentioned.

Senator Obama also proposes to demand full transparency of the costs incurred by the provider (Obama Campaign, 2007). This method is expected to inhibit the providers from overcharging the patients and insurance companies, allowing the insurance companies and patients to evaluate what they are paying for and act accordingly, hence fostering some form of market-oriented environment for price adjustment.

B. Pharmaceuticals

Senator Obama, proposes to increase competition in the pharmaceutical industry by allowing drug re-importation. Re-imported drugs, which often are the exact same products, from the same manufacturers, while costing only a fraction of the cost in the United States, would be available to the domestic consumer at much lower cost. Curiously, this would, in a sense, cause the drug companies to compete with themselves, in spite having a monopoly on patent-protected products on the market. Moreover, foreign-produced pharmaceuticals would still have to meet the same FDA standards used within borders in order to be re-imported. This would be a highly effective way to introduce competition – entirely market oriented - that Senator McCain apparently missed entirely.

Secondly, to reduce the cost of pharmaceuticals, Obama will promote use of generic drugs, like it is done in Europe and third world countries. It is well known that patent protection is vital to foster R&D and innovation, thus allowing the manufacturers to enjoy – when the drug is successful – a period of total monopoly on its commercialization. There has been some controversy in that pharmaceuticals can have a twenty-year monopoly on their products, while most other patents are limited to seventeen years¹. Such extended time is problematic, considering that unique products (especially prescription drugs) are very inelastic and hence insensitive to price. This condition gives the pharmaceutical company the ability to charge his own price to maximize its own profitability.

On the other hand, as the research and development expenses can be extremely high – as well as the high

¹ This applies primarily to patents filed before June 8th, 1995

risk of the product being unsuccessful – all the financial return will necessarily have to come from the profits during its monopolistic period. Hence, a compromise is hard to find – maybe impossible – as any reduction of the period of patent right will contribute to either increase its price or constrain research for new drugs. The only apparent option is for the government to negotiate bulk purchases with the drug companies – or even buying the patent itself. However, even this could be problematic as it would be very expensive for the government to implement, while also not having any market-efficient method in setting prices.

It has been claimed that just the news of opening competition induced the pharmaceutical companies to lower their prices by up to 95% (Kidder, 2004) - a huge savings that the government and insurance companies could incur which, in turn, would reduce costs associate with health care.

Senator Obama, however, falls short in mentioning the importation of foreign-produced drugs, which would significantly increase the effect on price reduction.

Guaranteed Access

As he often mentions in his literature, Senator Obama is committed on guaranteeing access to health insurance. “Guarantee” is a strong word that he emphasizes in describing the access to health care. In principle, this would mean that anybody would get insurance no matter what: his official plan states “Guaranteed eligibility: No American will be turned away from any insurance plan because of illness or pre-existing conditions” (Obama Campaign, 2007). This is a very strong promise – if implemented, not only would this end the problems of adverse selection, but everybody would have access to health care, regardless of their health conditions.

A closer look into this statement, however, shows a potential highly problematic situation. In the event that interstate insurance can be done, we risk seeing a fragmentation of the system not unlike Senator McCain’s, where the sick would go to the less regulated agencies, while the healthy would go to others. On the other hand, should interstate barriers not be lifted, it would be reasonable to assume that insurance agencies would resort to covert forms of discrimination. Some examples include selective contracting, in which insurance companies would choose to contract with providers that offer services typically associated with healthy customers, while avoiding those that offer services with less healthy individuals, effectively discouraging the sick from selecting their plan.

Furthermore, it is unclear is how the plans would be paid for: would they be paid completely out of pocket, or would they be subsidized? Would Senator Obama offer health care vouchers as Senator McCain? How the premiums get financed is one of the most important aspects when determining the effectiveness of access to health care.

Ultimately, without supporting details or statistical data, it's hard to give too much credibility to this aspect of the plan. Currently, and until Obama elaborates more, the full accessibility promise cannot be characterised by anything more than a mere intention, as his critics often like to describe his plans as.

Conclusion

In principle, Senator Obama's plan contains several elements that would be necessary to promote low cost and high quality. Still, he falls short in providing enough credibility to some parts of the plan, due to the fact that it cannot be reliably evaluated because it does not provide any detail on how he would achieve his proposed results.

However, unless details are being withheld, and this could be the case considering at the time of writing it is still early on the nomination process, Senator Obama's plans raise some questions. He never effectively addresses how the premiums would be paid or how much would be spent. It is clear that he wants to force (or, rather, "ensure") the companies to charge a "fair" amount. Yet with such vague terminology, it is hard to foresee how his program would be implemented and to evaluate the results.

In summary, Senator Obama's plan health does offer some promise in improving the health care situation, yet many crucial details are lacking to make any kind of reliable analysis.

Final Thoughts

While both candidates are serious in the effort to contain the ever increasing costs of health care, their different approaches may lead to radically different results.

Since, as of the time of writing, their policies consist of little more than a list of principles or ideas, this lack of details in implementation makes it difficult to properly evaluate the performance of either candidate. As time goes on, however, and more details become available, then one could make a more informed decision.

One thing, however, is clear: in order to truly improve, the United States should choose a well-performing benchmark, that could be used as a valid measure of improvement (or lack thereof). This benchmark entity could also be used as a role-model: there is effectively little reason why the United States can't or shouldn't emulate better performing countries as a way to improve their own.

As it currently stands, the system favours the healthy or those with a job; anybody who is unemployed and has some problem in obtaining (or keeping) their insurance is effectively getting weeded out by society by mimicking nature, by allowing the strong (employed and/or rich) to survive, while eliminating the lower strata. While this approach may work well in business, where you want the best companies to survive, and finish the poor performing, playing with someone's life is an entirely different matter.

Additionally, the rising costs of insurance, which is most often a burden to the employer, takes the hidden form of higher-cost products. In an ever increasingly global and connected world, competition poses more and more pressure on businesses. Hence, the increasing prices of insurance, leading to increased prices of the products, makes the United States less competitive and, to a degree, risks losing its world dominance as an economic superpower.

Simply shifting costs to employees, as McCain suggests is like expelling beggars from the local community to another, neighbouring one: you only shift the problem, not solve it. While the companies would not (necessarily) pay for insurance, they would still have to somehow compensate the employees who are now faced with this burden, and consequently, would have to offer additional benefits, such as

increased salaries which, in turn, would raise the costs which, again, would raise the prices of the products.

One problem is that to effectively improve the conditions, the burden must not be passed, but eliminated. In order for this to happen, an entirely different approach must be taken such as, as previously mentioned, emulating the better performing countries, such as in Europe or Japan. However, all of them some form of socialised system, whereas the United States is (almost) purely driven by the private sector (or so most think).

Given that the well-being of the country's citizens is a general cultural demand, and seeing how social justice, such as affirmative action, often goes against the traditional market-driven approach, a social approach may be necessary, if not optimal. To be sure, basic education is already socialized in the US without by such being considered evil. The United States, understandably, has a certain fear of such terminology and attitude (think McCarthy). If the US were to relax such negative attitude against such an "evil" concept (taxation is legal and generally accepted, isn't it?), then and only then, could the US move to improve the system into something that it was meant to be: one of the best in the world.

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