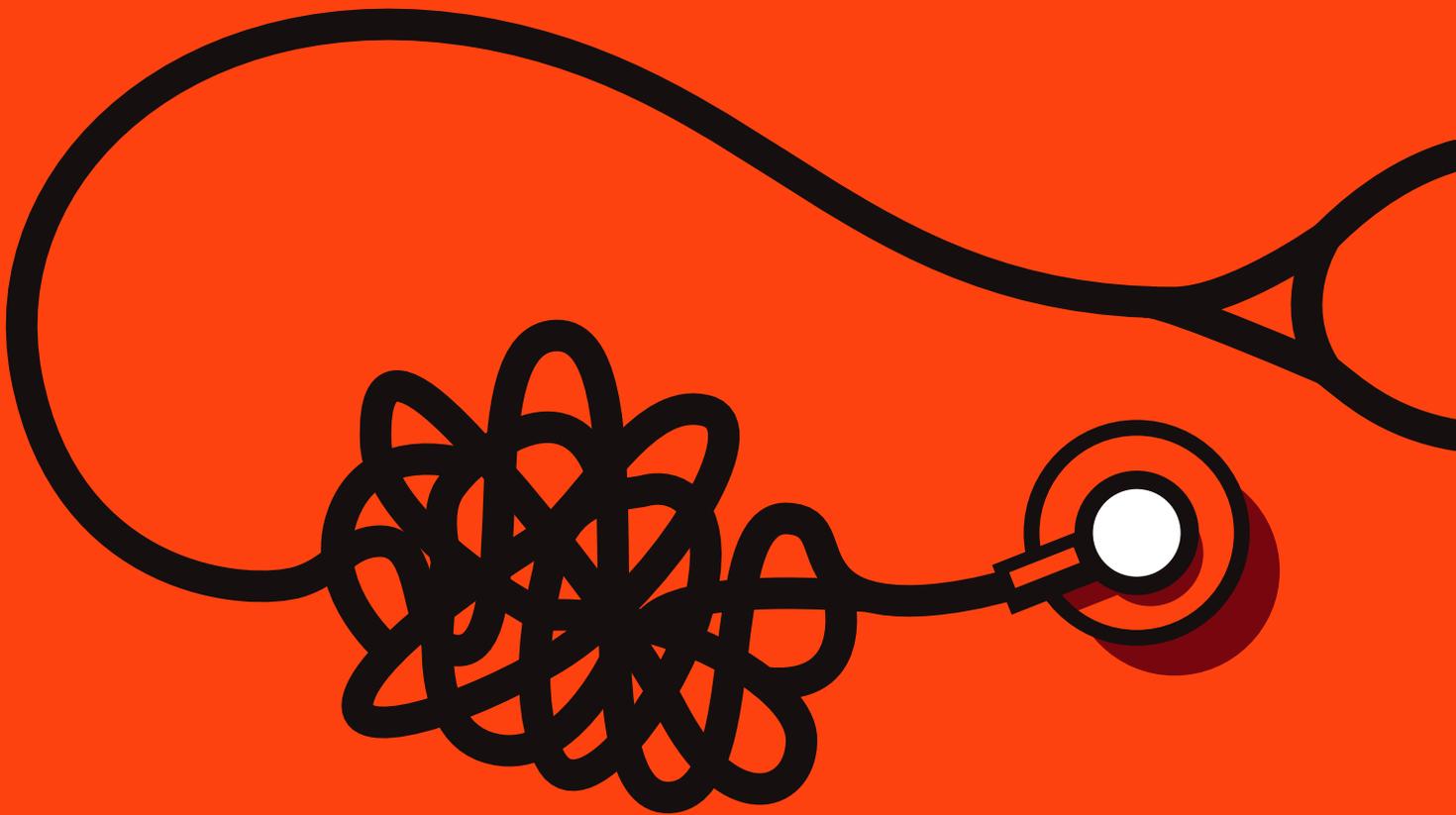


FEE's Guide to Health Care

ANSWERS TO THE
**HEALTH CARE
CONUNDRUM**



FEE's Essential Guide to Health Care Reform

*Essays from the Foundation
for Economic Education*

FEE

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Introduction

Health care policy rocks elections and dominates headlines for a reason. It gets to the core of how we live, even whether we live. The issue comes down to this. Should we trust government to manage this? Or should we let the competitive forces of the market deliver what we need?

You can gain some insight by reflecting on other parts of your life. Where do you shop for groceries, clothing, computers, make up? Do we have national plans and bureaucracies managing their creation and delivery? Absolutely not. We've learned from experience that leaving these sectors to market forces reduces prices, incentivizes creativity, and leads to mass consumption.

This is precisely how health care became amazing in the modern era. Government had no involvement at all until the first decade of the 20th century. Even then, it was mostly limited until after World War II. But the greatest explosion of health ever recorded in human history occurred in the 2nd half of the 19th century, before government had any hand in health care.

It is clear where we need to be headed with policy. But that is easier said than done. There are special interests. There are payoffs. There are bureaucracies to feed and politicians who wanted to demagogue the issue to achieve reelection. Unraveling this mess is a serious challenge. The main challenge is intellectual: all of us need to understand. This is the first step.

What follows is the essential guide to that understanding.

Is Health Care a Human Right?

Trevor Burrus

Is there a right to health care? Most libertarians and classical liberals would say “no,” and most progressives are shocked by that answer. For progressives, nothing could be more obvious than that everyone deserves access to health care regardless of their ability to pay. Distributing medical care based on wealth is for dystopian science fiction stories, where the underclass gets back-alley doctors and the ruling class gets sleek, modern hospitals. It doesn’t belong in a civilized society.

Thus progressives ask, how can libertarians be so heartless as to not believe in a right to health care?

In this essay, I will try to answer that question. While I might not convince you that there isn’t a right to health care, I hope to at least convey that, whatever a “right” to health care is, it is something fundamentally different from the sort of thing we usually call a “right”—so different, in fact, that we probably shouldn’t be using the same word.

I’ll be narrowly focused on that question. This essay is not about how the free market can solve health care, it’s not arguing that health care isn’t crucial to a flourishing life, and it doesn’t claim that America’s health care system is better than systems where people do have a “right” to health care. It’s only about whether it makes sense to call health care a “right.”

What We Mean When We Say, “Rights”

In October 2017, the National Health Service, Great Britain’s single-payer, socialized healthcare provider, announced that smokers and the obese would be banned from non-urgent surgery indefinitely. According to [the Telegraph](#):

[T]he new rules, drawn up by clinical commissioning groups (CCGs) in Hertfordshire, say that obese patients “will not get non-urgent surgery until they reduce their weight”...unless the circumstances are exceptional.

The criteria also mean smokers will only be referred for operations if they have stopped smoking for at least eight weeks, with such patients breathalysed before referral.

The policy change understandably received significant criticism and brings to the fore the true meaning of “right” to health care.

What is a right? Even though “rights talk” permeates our political conversations, most people have never tried to define a right. Sometimes the term is used as a synonym for “important”—thus we hear about a right to clean water, shelter, education, and healthcare, all of which are undoubtedly important.

Yet having a “right” to something means more than that. Saying something is a “right” describes a relationship between individuals. It makes us think about our obligations to each other and the government’s obligations to its citizens. Rather than focusing on *what* we have rights to, I’d like to focus on the *relationships* that a “right” creates and the distinction between positive and negative rights.

Rights describe a relationship between at least two people: a rightholder and a duty-holder. If someone has a right, others have a corollary duty. They’re inextricably linked; two sides of the same coin.

Think of a desert island with only Robinson Crusoe, before Friday arrives. Crusoe could tell the trees and the animals that he has a “right” to life, but would it mean anything? A tiger chasing him through the grass is immune to Crusoe’s right-claim. Tigers can’t be duty-holders, so the term “right” does not describe a relationship between Crusoe and the tiger. When Friday arrives, however, Crusoe’s claim that he has a right to life implies something about the relationship between him and Friday. If Crusoe has a right to life, then Friday has a duty not to murder him, and vice versa.

The nature of the corollary duty is what distinguishes positive rights from negative ones. For negative rights, the corollary duty is an omission—that is, duty-holders are required to refrain from doing

something, e.g. don't steal, don't punch people, don't kill. For a positive right, the corollary duty is a duty of action—that is, duty-holders are required to affirmatively act, e.g. provide food, provide health care, or provide resources for such things. Understanding this technical, but crucial, difference between positive and negative rights can help us identify four qualities that make them categorically different.

Negative Rights are Absolute; Positive Rights Are Not

Negative rights can be enjoyed absolutely in a way positive rights cannot. Assuming no one is killing you (I hope), currently, you, the reader, are fully and absolutely enjoying your negative right to life. Similarly, if no one is stealing from you, assaulting you, or otherwise violating your body or your property then you are absolutely enjoying your negative rights to not be stolen from, assaulted, etc., and everyone else is absolutely fulfilling their negative duties.

Can positive rights can be enjoyed absolutely? It's difficult to imagine how. If there is a positive right to health care, how much health care does that entail? When has the positive duty been fulfilled? If even one person enjoyed an absolute, positive right to health care, then, at least theoretically, every duty-holder would have to devote all of their time and resources to keep the rightholder alive for even one extra day. But that's ridiculous, and no one is claiming that. If not, however, then what are they claiming?

Most people would say that a “right” to health care guarantees some baseline care. They grant that because resources are limited, choices have to be made. Britain's NHS, for example, **recently deemed** six breast cancer drugs as “insufficient value for the money,” even though some of the drugs had been shown to extend lives by months, if not years. And when the NHS decided to bar obese people and smokers from certain types of non-urgent surgery, those unfortunate cast-outs must have wondered, “I thought I had a right to health care.” In fact, **in a survey conducted in 2015**, 75 percent of British doctors had seen care rationed, including the rationing of mental health care and knee and

hip replacements. If you can get a knee or hip surgery in the U.K., the average waiting time is **nearly a year** compared to three to four weeks in the U.S.

Some argue that this question—how much health care do you have a right to?—can and should be answered by scientists, doctors, and policy experts, which is essentially how single-payer systems like the NHS deal with rationing. This raises a crucial and recurring point: *if “experts” are deciding how much health care someone receives, then the issue is being resolved by considerations other than the right-claim.* In other words, positive rights are *inconclusive*, in that they fail to answer our moral questions and, in fact, often just make them more difficult or insoluble.

The inconclusivity of positive rights makes them very different from negative rights. When someone claims a negative right to life, the corollary duties—who has them and what they have to do to fulfill them—are *fully answered by the right-claim.* While a claim to a negative right is sufficient to resolve an issue, a claim to a positive right merely inaugurates a conversation about other moral considerations. Should the young get more than the old? The skinny more than the obese? Is long-term pain amelioration, such as a back surgery, a better use of resources than giving a 95-year-old a few more weeks to live?

Obviously, because we don't have infinite resources, such decisions have to be made. But that very fact makes positive rights categorically different from negative rights. There's no plausible reason for politicians to consider taking away negative rights from entire classes of people—they couldn't, for example, proclaim that stealing from smokers or the obese is legal.

Negative Rights are Scalable; Positive Rights Are Not

If you're fully enjoying your negative right to life, then every person on the planet is currently omitting killing you. If we doubled the population of the Earth tomorrow, it would be easy for every new person on the planet to omit killing you too. Someone can easily take on an infinite number of duties of omission and extend those duties to an infinite number of

rightsholders. Doubling the population doesn't fundamentally change any question regarding who enjoys negative rights and who has a duty to respect them. The answer is simple: everyone and everyone, all the time.

The scalability of negative rights makes them truly universal rights. Negative rights make no distinctions based on citizenship, country of residence, or other forms of legal status. In fact, enjoying a negative right, properly conceived, requires no citizenship, legal status, or even government. True, it might be difficult to enforce your negative rights in the absence of a government, but that doesn't alter the moral status of your negative rights. Critics of the positive-negative distinction sometimes inappropriately conflate the cost of producing goods and services to satisfy positive-rights claims with the cost of police, courts, and prisons to punish infringements on negative rights, but that's a category error. "I'm entitled not to be stabbed," is a different matter than, "I'm entitled to have my attacker investigated and jailed."

Positive rights, in contrast, are not universal—they're conferred by virtue of one's legal status, such as citizenship. This means, as we've seen, they can be taken away or altered at the caprice of government officials, as was the case with Britain's obese and smokers. In 2009, under Massachusetts's "universal" health care system, 31,000 legal immigrants had their state-subsidized health insurance **scaled back** in order to counter budget shortfalls. While this might be required when resources are limited, it only underscores the fundamental difference between positive and negative rights.

Negative Rights Can Easily Exist Together; Positive Rights Cannot

While people can take on an infinite number of duties to omission, they can only take on a finite number of duties to act. Positive rights, therefore, exist in an uneasy relationship with each other. If there is a "right" to healthcare, education, clean water, and even a vacation, then what happens when there is a conflict between two affirmative duties?

Recently, the European Union **declared** that traveling for vacation is a human right, and announced plans to subsidize travel for disadvantaged

people. Yet there is also a right to health care in the European Union, so what happens when a doctor's right to go on vacation encounters a patient's right to health care? The conflict is never that direct, of course, but positive rights, by necessity, must conflict all the time.

Like the question of how much health care someone will receive, these conflicts are "solved" by policy experts and politicians. Once again, we see the invocation of a positive right failing to solve the moral question, ultimately just kicking it upstairs instead. Whereas negative rights can exist together simultaneously, positive rights form an uneasy and inconsistent tableau of mutually unsatisfiable claims. Philosophers, such as Hillel Steiner, have called this trait *compossibility*, or the ability to exist together. Whereas all negative rights are compossible, positive rights are impossible.

Negative Duties are Universally Shared; Positive Duties are Not

With negative rights, the corollary duties are equally shared by all duty-holders. No one is exempt from the obligation not to kill, steal, or assault. With positive rights, however, the corollary duties are not equally shared. As with the questions of who has a right to health care and how much do they get, we encounter further questions of who has to provide health care (or contribute to the provision) and how much they have to provide.

Again, whereas as negative right-claims require no additional moral considerations in order to determine who has a right, who has a duty, and what the nature and extent of that right/duty relationship, positive rights require secondary considerations in order to resolve the inevitable questions. Practically speaking, those questions are resolved by politics, and thus are subject to political winds.

Positive “Rights” Are Just Politically Contingent Claims to Something

Negative rights are absolute, scalable, compossible, conclusive, and universal. Positive rights are not absolute, unscalable, impossible, inconclusive, and restricted. Positive rights are something else entirely. It’s difficult to come up with a precise term, but a positive right to health care is little more than a politically contingent claim to some health care, revocable and modifiable by morally irrelevant factors.

There’s something deeply problematic about denying people health care based on extrinsic, contingent, morally irrelevant factors. When smokers made up a larger percentage of the British electorate, the NHS wouldn’t have dreamed of denying them surgeries due to the political backlash they would have faced. Now, because smoking is becoming increasingly unpopular and morally charged among the ruling classes, smokers can be denied access to health care.

Some may say it is perfectly sensible that smokers are denied access due to their unwise decision to harm themselves while expecting others to pay for it. There is a right to health care, the argument goes, but no one has a right to make poor decisions and expect others to bear the costs.

This is a perfect example of the inconclusivity of positive rights. The initial claim to a right to health care only begins the inquiry into who, when, and how that right will be enjoyed. Smokers and the obese are being excluded based on a secondary moral limitation that exempts some people based on a political calculation, demonstrating that a positive right is less a *human* right and more a *political* one.

Moreover, in health-care systems like Britain’s, all people are forced to pay for the NHS to some degree, and private medicine is a **small, niche market** because the NHS crowds out the alternatives. Smokers and the obese are largely unable to pay for their decisions themselves, even if they would prefer to. Perhaps some would like to exit the NHS so their health care options weren’t determined by a political board, but there are few exit options available, especially at lower incomes.

Most important, however, is whether it is morally proper to deny people health care based on their membership in politically unpopular groups. Furthermore, even if it is proper, is it correct to call that a “right?” Such a question may seem easy when talking about those who are widely scorned, such as smokers and the obese, but what

about homosexuals? During the 1980s, when AIDS swept through the homosexual community, **some argued** that they deserved their fate because they committed self-harm while expecting others to pay for it. During that time, and especially a decade before, it would have been very difficult for the gay community to muster up enough political support to protect their “right” to health care. Relying on politics seems fine until you’re on the other side of it.

Conclusion

Astute readers might argue that allowing the market to “distribute” health care rests on equally morally irrelevant factors, primarily the ability to pay. I concede that point to a degree. This essay, however, is not about whether the market distributes health care in a morally justifiable way, but whether there is a positive right to health care.

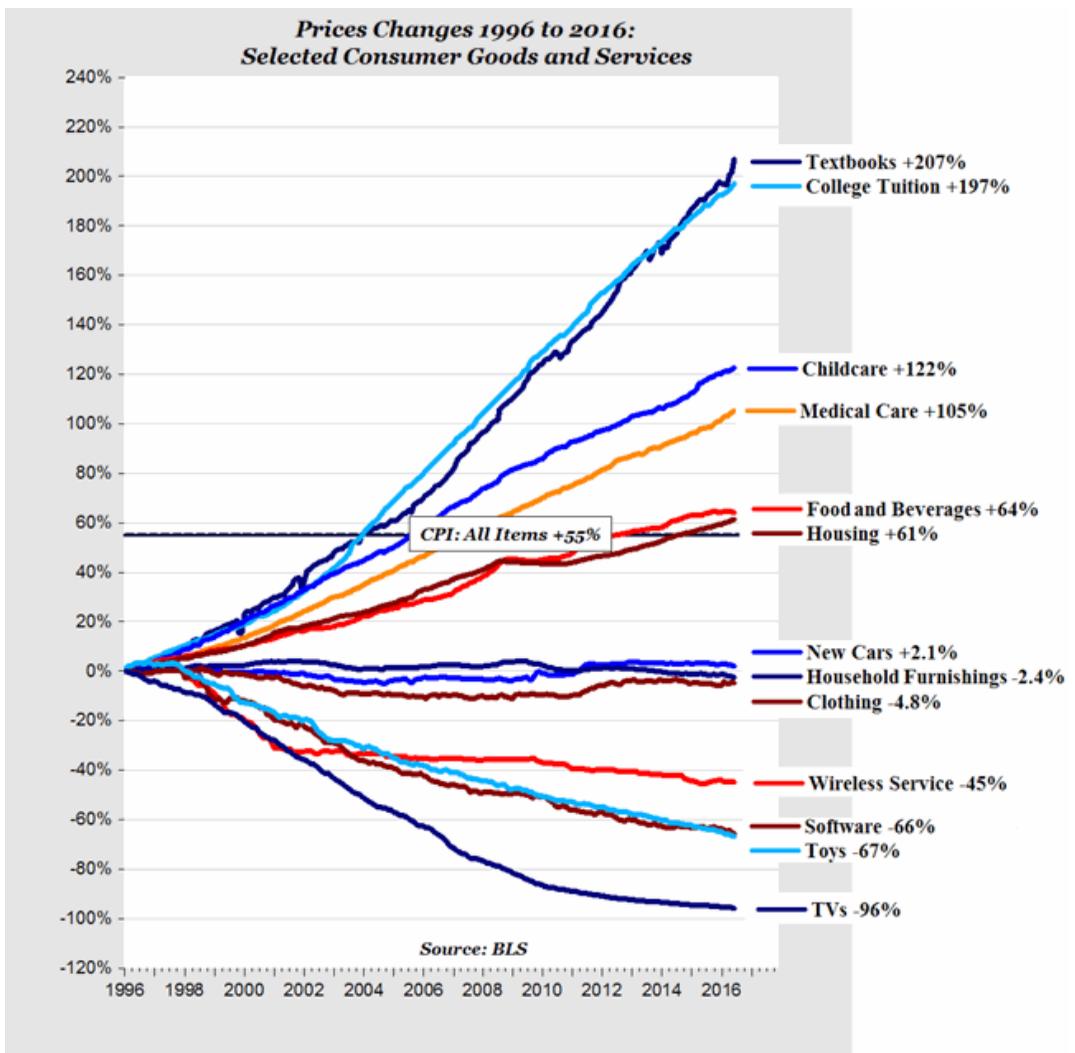
If we can find no such right, it doesn’t mean that healthcare is unimportant or that we don’t have other moral obligations related to the health and well-being of our fellow citizens. I believe we have contingent moral obligations to help out those in need—contingent upon first being able to satisfy our other obligations. After you’ve put a roof over your head, provided for the care and well-being of your children and loved ones, and established some amount of security in your life, you have a moral obligation to help out those in need. That, however, is not a “right” to health care.

If health care is not a right, that’s okay, because it’s not the same as saying health care is unimportant. Rights, properly understood, explain the minimal normative obligations required for human beings to live together cooperatively rather than combatively. If you don’t hit me, kill me, or steal from me, then I’ll behave the same toward you, and we can thus be members of the same community based on a system of trust and mutual respect. Rights do not exhaust, however, the maximal normative obligations that may be required of us. That shouldn’t bother us because rights can’t do more than negatively prescribe our basic boundaries. By focusing on “rights to important things”—e.g. water, health care, education, shelter—the term is perverted and used to claim more than can be justified.

Why Luxury TVs Are Affordable when Basic Health Care Is Not

Richard N. Lorenc

Imagine this. You are feeling under the weather. You pull out your smartphone and click the Rx app. A nurse arrives in 20 minutes at your home. He gives you a blood test and recommends to the doctor that she prescribe a treatment. It is sent to the CVS down the street, which delivers it to your door in 20 minutes. The entire event costs \$20.



Sounds nuts? Not so much. Not if health care were a competitive industry. As it is, medical care prices are up 105% in the last 20 years. This contrasts with the television industry, which is selling products that have fallen 96% in the same period.

Take a look at this chart assembled by AEI. It reveals two important points. First, there is no such thing as an aggregate price level, or, rather what we call the price level is a statistical fiction. Second, it shows that competitive industries offer goods and services that are falling in price due to market pressure. In contrast monopolized industries can extract ever higher rents from people based on restriction.

Consider each product or service shown. College is heavily subsidized, regulated, and exclusionary, and the costs are soaring. The textbook industry is hobbled by extreme copyright regulation, and can depend on captive buyers. Childcare is one of the most regulated industries in the country. Not just anyone can enter. Every aspect of childcare provision is controlled by the state.

On the other hand, software, wireless service, toys and and TVs (see: free trade) exist in relatively freer market settings. The price pressure is down.

It's not that complicated, folks. If you want good services, good products, innovative ideas, and low prices, you need competitive markets. The more you control, the higher the prices and the worse the results.

Could the Uber Model Work?

Charles Hughes

Patients are often insulated from the cost of health care services and at an informational disadvantage. It is hard for patients to determine the quality of those services, and they do not have much of an incentive to check. This can create a situation where patients spend more for the health care services they consume, in what is called a moral hazard problem.

The Moral Hazard Problem

Moral hazard has been studied extensively from the consumer side. How providers respond in these situations is less understood, but also important. It could help explain why prices are growing rapidly in areas as diverse as health care, financial services, or even taxi rides.

If taxi drivers think their passengers lack the ability to check, they might overcharge or take a route that is longer than necessary. Riders on a business trip who are getting reimbursed by their companies might not care as much about cost, increasing the opportunity for drivers to charge more.

A new [paper](#) in the February issue of *The Economic Journal* details the extent that traditional taxi drivers charged riders more when this opportunity arose. Drivers were told the riders were new to the city and being reimbursed by employers, so there was a reduced check on the routes they took or prices they charged. Taxi drivers systematically charged these riders more.

In their experiment, the authors used a controlled field experiment to try to determine if taxi drivers charged more to riders when the rider told them their employer is reimbursing them for the trip. In this instance, the drivers might take a longer route or overcharge because

they infer that the rider does not care as much about the price, because they are not paying for it directly.

As a test, research assistants took 400 taxi rides in Athens, Greece. Each time the rider told the driver they were unfamiliar with the city. Some riders also told the drivers they needed a receipt so the expense could be reimbursed by the employer. The authors deem this the “moral hazard treatment” as the driver could now infer that the rider is less likely to notice, or report, dishonest behavior.

There are two main ways drivers could take advantage of the uninformed and insulated consumer. They could overtreat, in this case taking an unnecessarily long route or detour. They could also overcharge.

A third mechanism, undertreatment, is not as feasible for taxis rides, because even uninformed riders would likely be able to perceive if they did not arrive at their destination. In other fields, such as health care, undertreatment could be more prevalent.

Overcharged

In the experiment, riders that gave notice of employer reimbursement were 17 percent more likely to pay higher-than-justified prices for a given ride, and paid about 7 percent more on average. While there were significant differences in terms of overcharging, there was no such difference when it came to overtreatment.

This could be because drivers view overtreatment as easier to detect, as someone can tell if they are going in circles or winding their way around the city more easily than if they were simply being charged more. The extent of overcharging indicates a substantial provider response to the moral hazard problems.

In other fields where it is even harder for consumers to verify quality of services, such as finance, overtreatment and undertreatment could play a larger role.

From Taxis to Health Care

Just as with the taxi drivers in Greece, providers respond to this moral hazard problem by overcharging. The authors describe physicians in Germany, who charging patients for services that were never rendered.

One analysis by **Walmart** of employee experiences found that about 30 percent of the spinal procedures that employees were told they needed were not appropriate. This response from providers results in higher costs and services that consumers do not necessarily need or want.

Uber's pricing system, which requires a receipt with the name of the driver and with a map for the rider, is just one example of a new technology that protects uninformed consumers from being overcharged. Similar transparency in other fields, such as health care, could bring substantial benefits to consumers and rein in cost growth.

Real Health Insurance Is a Crime

Warren Gibson

Health insurance is a crime. No, I'm not using a metaphor. I'm not saying it's a mess, though it certainly is that. I'm saying it's illegal to offer real health insurance in America. To see why, we need to understand what real insurance is and differentiate that from what we currently have.

Real Insurance

Life is risky. When we pool our risks with others through insurance policies, we reduce the financial impact of unforeseen accidents or illness or premature death in return for a premium we willingly pay. I don't regret the money I've spent on auto insurance during my first 55 years of driving, even though I've yet to file a claim.

Insurance originated among affinity groups such as churches or labor unions, but now most insurance is provided by large firms with economies of scale, some organized for profit and some not. Through trial and error, these companies have learned to reduce the problems of adverse selection and moral hazard to manageable levels.

A key word above is unforeseen.

If some circumstance is known, it's not a risk and therefore cannot be the subject of genuine risk-pooling insurance. That's why, prior to Obamacare, some insurance companies insisted that applicants share information about their physical condition. Those with preexisting conditions were turned down, invited to high-risk pools, or offered policies with higher premiums and higher deductibles.

Insurers are now forbidden to reject applicants due to preexisting conditions or to charge them higher rates.

They are also forbidden from charging different rates due to different health conditions — and from offering plans that exclude certain coverage items, many of which are not “unforeseen.”

In other words, it’s illegal to offer real health insurance.

Word Games

Is all this just semantics? Not at all. What currently passes for health insurance in America is really just prepaid health care — on a kind of all-you-can-consume buffet card. The system is a series of cost-shifting schemes stitched together by various special interests. There is no price transparency. The resulting overconsumption makes premiums skyrocket, and health resources get misallocated relative to genuine wants and needs.

Lessons

Some lessons here are that genuine health insurance would offer enormous cost savings to ordinary people — and genuine benefits to policyholders. These plans would encourage thrift and consumer wisdom in health care planning, while discouraging the overconsumption that makes prepaid health care unaffordable.

At this point, critics will object that private health insurance is a market failure because the refusal of unregulated private companies to insure preexisting conditions is a serious problem that can only be remedied by government coercion. The trouble with such claims is that no one knows what a real health insurance market would generate, particularly as the pre-Obamacare regime wasn’t anything close to being free.

What might a real, free-market health plan look like?

- People would be able to buy less expensive plans from anywhere, particularly across state lines.

- People would be able to buy catastrophic plans (real insurance) and set aside much more in tax-deferred medical savings accounts to use on out-of-pocket care.
- People would very likely be able to buy noncancelable, portable policies to cover all unforeseen illnesses over the policyholder's lifetime.
- People would be able to leave costly coverage items off their policies — such as chiropractic or mental health — so that they could enjoy more affordable premiums.
- People would not be encouraged by the tax code to get insurance through their employer.

What about babies born with serious conditions? Parents could buy policies to cover such problems prior to conception. What about parents whose genes predispose them to produce disabled offspring? They might have to pay more.

Of course, there will always be those who cannot or do not, for one reason or another, take such precautions. There is still a huge reservoir of charitable impulses and institutions in this country that could offer assistance. And these civil society organizations would be far more robust in a freer health care market.

The Enemy of the Good

Are these perfect solutions? By no means. Perfection is not possible, but market solutions compare very favorably to government solutions, especially over longer periods. Obamacare will continue to bring us unaccountable bureaucracies, shortages, rationing, discouraged doctors, and more.

Some imagine that prior to Obamacare, we had a free-market health insurance system, but the system was already severely hobbled by restrictions.

To name a few:

- It was illegal to offer policies across state lines, which suppressed choices and increased prices, essentially cartelizing health insurance by state.
- Employers were (and still are) given a tax break for providing health insurance (but not auto insurance) to their employees, reducing the incentive for covered employees to economize on health care while driving up prices for individual buyers. People stayed locked in jobs out of fear of losing health policies.
- State regulators forbade policies that excluded certain coverage items, even if policyholders were amenable to such plans.
- Many states made it illegal to price discriminate based on health status.
- The law forbade associated health plans, which would allow organizations like churches or civic groups to pool risk and offer alternatives.
- Medicaid and Medicare made up half of the health care system.

Of course, Obamacare fixed none of these problems.

Many voices are calling for the repeal of Obamacare, but few of those voices are offering the only solution that will work in the long term: complete separation of state and health care. That means no insurance regulation, no medical licensing, and ultimately, the abolition of Medicare and Medicaid, which threaten to wash future federal budgets in a sea of red ink.

Meanwhile, anything resembling real health insurance is illegal. And if you tried to offer it, they might throw you in jail.

Ten Principles of Health Care Reform

- Government should not be determining what is or must be insured. That should be up to the consumers to decide.

- Government should not interfere in contractual relationships between providers and purchasers of insurance, whether individuals or businesses.
- Prices for medical services need to be completely decontrolled, and the convoluted market-rigging by a conspiracy of providers, insurers, and government welfare bureaucracies must be ended.
- Government should not mandate coverage by employers or privilege employer-provided coverage over individually purchased coverage. Third-party payment should be an option.
- Government should not mandate that insurers accept all comers at the same price; that system makes a mockery of the whole idea of insurance itself.
- Discrimination for “pre-existing conditions” should not be a criminal act but rather a rational consideration for determining premiums.
- Government should not restrict who gets to try their hand at providing insurance; entry and exit need to be competitive too.
- Government should never force anyone to pay for a service that he or she does not want. You say coverage is a human right? It’s a human right for a person to refuse coverage.
- If you want to get serious about fixing the system, the byzantine pharmaceutical system has to go. Again, let the consumers decide, and, while we are at it, there should be complete free trade in medicine.
- The 100-year old medical credential monopoly that has so severely restricted entry into the profession should be dismantled. The market is fully capable of assuring quality, and remember too that there is not one definition of quality.

FEE's mission is to inspire, educate, and connect future leaders with the economic, ethical, and legal principles of a free society.

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