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COMMENTARY

David L. Debertin on...

The Rural Health Care Dilemma

Debate rages over the need to revamp the U.S. health care system. Conservatives argue that market-oriented solutions will lead to the most efficient allocation of health care services. Liberals argue that market-oriented systems for the delivery of health care cannot be made to work, and point to the claim that the United States is the only industrialized nation without a comprehensive national health insurance system.

It is clear that the current system is not working. Medical doctors are locating where they can make the most money, which usually means the larger cities. My home town in rural North Dakota has an excellent clinic, but you must make certain that you need medical services only on Tuesday or Thursday, because those are the only days a doctor will be present. Doctors serve the clinic on a rotating basis, traveling from Minot, sixty miles away. My 80-year old father recently fell on a Friday afternoon, then suffered and waited until the following Tuesday before seeing the doctor at the clinic.

Those who press for a continuation of the current mixture of public and private insurance argue that under a nationalized health insurance system there would not be enough health care services to go around, putting the federal government in charge of rationing the care. But the current system also rations care. People who can afford the most expensive insurance policy that "covers everything" receive the best care. Those who cannot afford such high-priced insurance policies are subject to rationing. High deductibles (often $300 per family member or even more) coupled with co-payment requirements (such as 80-20 plans above the deductible) are strong obstacles to obtaining needed health care.

Five Principles

Rural residents have the most to gain or lose in the debate. A comprehensive health care policy from their perspective should emphasize these principles:

(1) The quality of health care should not be a function of where the resident lives. Every American should have equal access to health care regardless of residence in an urban or rural area.

(2) The quality of health care should not be a function of what the consumer can afford to pay for a health insurance policy. Either federal or privately-run, there should only be one health insurance policy, one that provides comprehensive care without co-payments and deductibles.

(3) Economic incentives to doctors should encourage them to locate in areas where they are in most need, and away from heavily populated urban centers where doctors are already in oversupply. We do not have a doctor shortage nationwide, but we do have a serious doctor-location problem.

(4) Economic incentives should encourage cooperation, not competition among hospitals. Observation of Lexington hospitals suggests that competition among hospitals does not lower costs of providing hospital services to patients. Instead, competition leads to duplication of services and equipment. New surgical procedures in many cases have reduced or eliminated the need for hospital stays. But the hospital-bed building binge continues unabated in many urban areas, and the consumer pays for the cost of the empty beds whenever a hospital stay is required. No hospital wants to find itself in a position of not having the latest equipment, and this too drives up costs.

(5) Malpractice insurance costs should be controlled in some way. Perhaps the federal government could do what the private insurance companies are unable to do, set limits on the amounts that patients (and lawyers) could collect on malpractice claims.

David L. Debertin is Professor, Department of Agricultural Economics, University of Kentucky.

Nationalized System

It is clear to me that the current system must be reformed. As a conservative, I have trouble suggesting that a comprehensive national health insurance plan might be the preferred approach. But I am firmly convinced that the current system embodying a mixture of private insurance and public support is coming apart at the seams. Pouring more federal money into the current system is only a temporary fix, and a comprehensive national plan may be the only logical alternative. The nationalized Canadian system is by no means perfect, but I believe that it is superior in many respects to our own.

What is the additional cost of a fully nationalized system beyond what we are currently paying for medicare and medicaid? My guess is $250-$300 billion annually, or approximately $1,000 per person. This is a lot of money in an era of big budget deficits, but cheap compared with what a trip to Mars costs. These numbers also compare with $118 billion for the NASA's proposed space station. Some money could, of course, be raised by increasing federal taxes on goods known to have deleterious impacts on health and therefore the costs of health care. The Canadian experience may be instructive here as well.

Minimum Steps

At a minimum the Federal government should effect some changes our current system seems unable to accomplish. For example, setting a fee structure that encourages doctors to locate in areas of greatest need, might not be popular with organizations such as the AMA. However, such a policy could effectively restructure access to the health care system in rural areas and inner cities. Other steps, such as taking control of the entire malpractice insurance business, might prove extremely popular with doctors. But such a plan is not likely to be enacted by a lawyer-dominated Congress. And the federal government could, in some cases, be able to force cooperation among competing urban hospitals, and thereby reduce excessive costs tied to duplication of expensive equipment. C