Back in the U.S.S.R.

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With the effective passage of the Medicare drug bill, we have just vastly enlarged the health-care sector. This is the one-seventh of our GDP that is run Soviet-style: where the doctors who are uniquely qualified to create and manage health-service businesses are prohibited from owning most of them; where entrepreneurs often must pass a local government smell-test before they are permitted to build new facilities; and, worst of all, where government dictates the prices and exact characteristics of the insurance benefits for which it will pay. Most private health insurers follow its lead.

Small wonder that health-care costs rise at double-digit rates, while the rest of our economy perks right along. Back in the U.S.S.R.

The U.S. economy has boomed because brilliant entrepreneurs can enter it freely. If they succeed, they are appropriately lionized. A McKinsey report claims that the retailing industry was No. 1 in enhancing productivity, and credits Sam Walton's Wal-Mart for much of that increase. No. 2 was the finance sector, whose productivity was greatly enhanced by John Bogle's dogged insistence on the wisdom of indexed, consumer-driven mutual funds. Yet, had Messrs. Bogle and Walton been forced to rely on government approvals to start their businesses and on government-dictated products and prices to earn their revenues, we might not have benefited from the productivity-enhancing innovations they created. Indeed, they would have been chopped off at the knees if they were in the health-care sector: It prohibits physicians, the health-care equivalent of Messrs. Bogle and Walton, from owning their own facilities. The unattractiveness of these conditions explains why few of the 100 Harvard MBA students enrolled in my "Innovating Health Care" course plan to enter the trillion-dollar health-services sector.

Further, because Medicare prices are dictated by government and do not reflect marginal costs, capital is misallocated. Among other things, this has produced vast temples to cardiology, a service Medicare has overpriced; and shreds of services for emergency care, a service that Medicare has underpriced. And because Medicare dictates product specifications, it penalizes innovations. For example, Duke University's Medical Center improved the health of victims of congestive heart failure and vastly reduced costly hospitalizations by integrating into one team the many different providers required for appropriate care for this disease -- who

normally do not communicate with each other -- saving $8,600 per person. But Medicare pays Duke primarily for hospital-based care. There is no standard-payment code for integrated care. In Medicare's straightjacket, the more Duke's innovation improved health and lowered costs, the more money the center lost.

Technology innovators also are penalized by delays and mispricing. For example, Medicare waited a full year to cover the implantable defibrillators that caused a 31% reduction in deaths, when compared to patients treated only with drugs. These high-tech, $25,000 devices can prolong lives for up to seven years. Without Medicare's coverage, some of those who could not afford to pay out of pocket surely died prematurely. Yet positive coverage decisions still do not assure access. If Medicare sets inadequate prices, providers lose money. Its price for implanting the drug-eluting stents that prevent reclogging of an artery, for example, eliminates hospital profits. Providers who implant do it as a charitable act.

Sure, it is great that seniors will now have expanded access to drug benefits. After all, the purpose of health insurance is to enable people to use services that they could otherwise not afford. But, can we have our cake and eat it too? Yes! With an American Revolution that replaces the Medicare entrepreneur-strangling apparatus with a market-based system of determining supply and demand. Consider the following example of how it would work for victims of congestive heart failure:

-- An innovative provider like Duke could offer its program at 20%-lower prices -- the savings it achieved. Innovators in drugs and devices could freely market them to these providers, who would determine their value for the money.

-- Enrollees could then select from different programs that offer complete, integrated treatment of their disease. Health-care clones of Consumer Reports would help them, just as people now get help buying computers and cars. Enrollees who opt for more cost-effective packages, such as Duke's, could use some of the savings for costly, uninsured needs, such as long-term care.

-- As for government, in a consumer-driven health-care system, such as Switzerland's, its role is to risk-adjust payments, so insurers and providers are rewarded for caring for the sick. Governments also prosecute incompetent, fraudulent providers and help the infirm and indigent.

Some economists believe that the health-care sector is optimally efficient: You can't make this orchestra play any faster. To them, only a single-payer system that eliminates redundant insurers and rations care can control costs. But a growing number of consumer-driven entrepreneurial insurance plans, intermediaries and health-care providers disprove such views the old-fashioned American way -- by increasing productivity. Such plans could be offered as options under the Medicare program.

In our traditional health-care system, a typical corporation limits the choice of health insurance plans to a single, one-size-fits-all plan. But consumer-driven insurance plans are designed for individual needs. The Minneapolis-based Vivius program lets enrollees choose the plan that best fits their budget from an a la carte menu of doctors, hospitals, deductibles and co-payments. Other plans let enrollees set aside funds in tax-free savings accounts for uninsured, important and costly benefits, such as drugs or long-term care expenses. The Illinois-based Destiny plan rewards health-promoting enrollees with lower costs. Some plans are relatively cheap; one provides insurance against catastrophic medical events for $1,500 for a single mom and two kids, unlike the typical $5,000 to $8,000 cost for such coverage. Sure, the plan has a $2,000 deductible, but it's a lot better than no insurance at all! Entrepreneurial firms help consumers sort through their options with the aid of skilled personnel, computer programs and hard data about the quality of doctors and hospitals.

Then there are the productive providers. A Minneapolis-based employers' consortium, BHCAG, permits doctors and hospitals to organize themselves into care systems, quote their own prices and determine for themselves how to best provide services. Innovative regimens like these reduce treatment costs by improving overall health.

Many people who favor centralized control defend the current state of affairs by scoffing at consumers' abilities. Health care is "too complex" for the likes of us to negotiate on our own. Without their savvy help, we would get lost. But somehow, we consumers have steadily improved the quality and beaten down the price of computers, cars and other complex products without their limiting our choice.

Others ask where governments could find the money for sick people who would favor plans that give them freer access to care. Hello?! Medicare expends that money right now! Under the Medicare regime, however, the money is spent cruelly, because it restricts care; and wastefully, because it shackles the innovators who represent the best promise for controlling costs, improving quality, and increasing the access to our health-care system. The competitive features of the new bill are a step in the right direction. But, if it went further, ending Medicare's pricing and benefit stranglehold and recognizing physicians' right to own facilities, we could replicate in our health care system the productivity gains we enjoy elsewhere in our economy.

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