IPS PRINCIPLE PERSPECTIVE

A Quarterly Update for Donors & Friends of IPS

3rd Quarter 2009

HEALTH CARE IN AMERICA

Our health care system is in crisis. Something needs to be done, and soon. But can we make an accurate diagnosis of the problem so that we can prescribe the best treatment?

FALL BIBLICAL PRINCIPLES *of* GOVERNMENT CLASSES

MODESTO, CALIFORNIA • LOS GATOS, CALIFORNIA

One of the primary goals of IPS is to educate Americans, and one of our core educational efforts is our 20-hour Biblical Principles of Government class, taught by IPS President Mike Winther. Mike has been teaching this class for over 15 years throughout Northern California, and we are pleased to announce that he will once again be teaching two simultaneous classes this fall, one in Modesto and one in Los Gatos. Northside Baptist Church in Modesto will be hosting us starting September 14, and Lone Hill Church in Los Gatos will be hosting us starting September 15.

It has been a number of years since Mike last taught this course in the Modesto area, so we are excited to be back in this location again. If you are interested in either of these classes, please see the flyer that is included with this issue of *Principle Perspective*, which contains more details including dates and times for both classes.

We are beginning some general promotional efforts for both classes, but we could use your help as well. If you would like to help us spread the word about this important class, please contact our office, or visit our website to obtain an informational flyer that can be reproduced and distributed. We hope to see many of you in September!

FIRST ANNUAL IPS DEBATE COACHES CONFERENCE

One of the greatest challenges to starting a debate program is finding a teacher for the activity. The creation of the Logos Forensics Association this year is no different. While many Christian schools have indicated their interest in academic debate for their students, the absence of a teacher with debate experience makes it difficult to start a school club or class. Recognizing this challenge, the Institute for Principle Studies hosted its first annual Debate Coaches Conference on July 15th - 17th.

Conference attendance was extended primarily to teachers at private schools, in order to give them a firm understanding of how the debate activity works and how to coach students. It was a small, but effective, start. During the three days of the conference, the participants were able to observe two debate rounds, understand debate's format and structure, learn types of argumentation, and hear about different coaching strategies. The teachers who attended demonstrated their excitement and enthusiasm for debate by actively participating and asking questions on every subject.

Debate tournaments for private schools will resume again this fall, and the schools that have joined with the Logos Forensics Association are gearing up and ready to teach their students everything they have learned. The Institute for Principle Studies will continue to provide assistance and materials to these new debate coaches and students, and we are looking forward to a new debate season and even further growth.

PLAYING FAVORITES: *Promoting Corruption*

One of the nearly-forgotten principles of good government is the principle of equality under the law. Without a firm dedication to this principle, government policy loses all consistency and begins to show favoritism to special interest groups. (For an explanation of the three kinds of equality, see our article entitled "Equality and Liberty: Friends or Foes" in the 2009 First Quarter issue of the *Principle Perspective*.)

Much of our current government activity could not exist if we required government to treat all of its citizens equally. We currently have programs that give tax incentives to one industry, in preference to other industries. We give tax credits to some first-time home buyers, but this credit is not available to all home buyers or to first-time home buyers that buy a home a day before or a day after the program eligibility dates. We woo the film industry back to California by giving them special treatment not afforded to other industries. Cities and counties attempt to recruit new jobs to their communities by offering tax discounts that are not offered to tax-paying businesses that already operate in their communitites. We give "cash for clunkers" as long as the consumer will buy a new, politically-correct vehicle.

These special privileges are just one more way that the government works to manage and control the economy. Government uses these inequalities of the law to influence where we live, where we work, how we invest, what we drive, the appliances that we buy, and the services we use. Some businesses go broke and others prosper based not on the quality of their product or on the price and efficiency of the product, but based on these government manipulations of the market.

Ignoring the fact that many of these programs are ethically wrong because they forcibly redistribute wealth, we must recognize that they also run afoul of this important principle of equality under the law.

Many of these government programs establish criteria for qualification in the program. Depending on the program, these criteria might include such things as participant income, age or value of the "clunker" car, the calendar date of a home purchase, etc. Each of these criteria, however, is subjective and arbitrary; there is no ethical, moral, or logical reason for the eligibility line to be drawn where it is.

It is this lack of legal consistency (we might call it a lack of uniformity) that makes it possible for lawmakers and bureaucrats to reward their friends and punish their enemies. These practices, of necessity, will corrupt both public officials as individuals and our government as a whole.

We must restore our nation's understanding of "equality under the law." We can do this by opposing any legislation that shows favoritism to any particular individual, group of individuals, or industries — even if we might be the beneficiary. IPS

Your Giving Matters

It is always difficult for non-profit organizations to raise funds — even more so in these challenging economic times. We want to express our appreciation to those who give, often sacrificially, to our work. Thousands of people are educated every year because you are willing to give a portion of your resources for the propagation of important truths.

The size and scope of our educational effort needs to expand, but it will soon contract unless we can attract additional resources. Given the state of the economy, it is no surprise that our revenues are down from last year. But if we could add 40 new monthly or quarterly donors, we could avoid any reduction of our outreach. If you are not a regular contributor to our work, please consider the cost of allowing our nation to self-destruct, and then consider the real benefit of becoming a regular contributor to IPS.

IPS has the answers that America is looking for. The question is this: will IPS have the resources to communicate these answers to America and the world?

HEALTH CARE IN AMERICA

By Michael R. Winther

The following article was originally published in early 1994. At the time that he wrote this article, Mike Winther was the Executive Director of the Society for Handicapped, a California based charity. Although this article was written over a decade ago, we feel that it is still timely and relevant to the health care crisis that is once again front-page news in America. We hope that this re-publishing will be of educational benefit to out current readership.

INTRODUCTION

The debate over health care in America is now front-page news almost every day. Everyone seems to agree that there is something wrong with the system and that something should be done — but what should we do? This issue is obviously important to all Americans, but it is of vastly greater importance to those who, because of disability or age, find themselves more dependent on medical care than the average American. The truth of the matter is that the disabled and elderly stand to benefit most from a good medical care system. Conversely, it is the disabled and elderly who will suffer the most from a bad system.

In this article, we will attempt to go past the political game-playing and look at the real causes and solutions of our health care woes. We will also look at the experiences of other industrialized nations that have tried systems very similar to what is being proposed in America.

PART ONE: Making the Proper Diagnosis

A good physician never prescribes medicine without first giving the patient a complete examination. The doctor knows that selecting the right medication depends on properly diagnosing the patient's condition. An incorrect diagnosis could result in the wrong drug being administered. The wrong medicine will certainly not promote the patient's health, and it may even prove fatal.

As we tinker with the health of an entire nation, should we be any less diligent in our diagnosis? After all, a doctor's incorrect diagnosis harms only one patient, but a misdiagnosis of our nation's health care system could devastate the health of tens of millions.

As I watch the health care debate, one of my greatest concerns is that there is very little emphasis on identifying the causes of the problem. Yes, everyone knows that health care costs are going through the roof, but do we really understand why? I doubt that one person in 100 really understands why costs are out of control, but most of these people think they have a solution anyway. Before we discuss possible solutions, let's make sure that we understand the problems and their causes. I have identified five factors that contribute substantially to the escalating cost of America's health care:

1. Inadequate supply of health care providers.
2. Over-use of services (excess demand).
3. Lack of consumer price consciousness.
4. Excessive regulation and mandated costs.
5. High-risk lifestyles and activities of Americans.

While this is certainly not a comprehensive list, it covers the causes most frequently identified by "experts" on all sides of the political fence. If this list does reflect the major causes of rising health care costs (which I believe it does), then any real "solution" to the health care crisis must address most, if not all, of these problems. Therefore, any "cure" that does not address these problems, or that makes one of these factors worse, is certainly the wrong medicine.

PART TWO: Supply & Demand

A Look at "Supply:" The first two items of the list relate to the supply and demand for medical care. An

understanding of supply and demand is absolutely essential to any discussion of prices. Price is simply where supply and demand meet. In this regard, medical care is no different than any other product or service. Everyone has heard of "supply and demand," but few people have applied this basic concept to medical care.

Imagine for a minute what would happen if we convinced one-half of America's doctors to retire. This instant shortage of doctors would result in long waits, and those doctors remaining in practice would raise their rates significantly. The reduced supply creates shortages and price increases.

Instead of retiring doctors, what if we could magically double the number of well-trained and qualified physicians? There would certainly be little or no wait to see a doctor, and prices for an office visit would drop considerably. The increased supply creates better availability and reduced prices.

The idea of increasing the number of doctors, nurses, etc. is a sensitive issue with medical professionals who don't want to see the standards of their profession compromised — or to see their profession flooded with additional competition. But the truth of the matter is that there is no oversupply of health care providers; in fact, just the opposite is true. Statistics on the average work week of U.S. physicians reinforces what local doctors tell me: they are working very long hours, they are seeing more patients than ever before, and they still cannot keep up with demand. An article appearing in the July 27 issue of the *Washington Times* stated that, "U.S. physicians fresh out of their residencies are being riddled with job offers." The article continues, "Two-thirds of young doctors receive at least 50 job offers during their residencies and almost 50 percent receive more than 100."

The U.S. has approximately 120 medical schools that each average about 100 admissions a year. U.C. Davis Medical School, with 93 positions, has over 5,000 applications each year. Some medical schools will have over 10,000 applications this year. Unfortunately, many of our best and brightest students will never make it into medical school.

Instead of increasing medical school enrollment, some medical schools have actually reduced the number of annual admissions. In the mid 1980s, U.C. Davis Medical School admitted 100 students each year; they now admit 93.

As our population has grown larger and older, our supply of trained doctors, nurses, and other professionals has not kept up with the increased demand. It should come as no surprise that health care costs are rising. What is surprising is that none of the current health care proposals make any effort to deal with the supply of health care providers.

A Look at "Demand"

The demand for health care services is indeed increasing significantly in America. There are four major causes of this surge in demand: 1) the aging of America; 2) poor health habits and lifestyles of Americans; 3) the needs of Canadians and others who purchase much of their medical care in the U.S.; and 4) the increasing prevalence of third-party payers (insurance). The first two factors on this list are widely discussed in the media, but the last two are largely ignored.

Most commentators have discussed the impact of an aging population on the demand for medical care. As medical science enables us to live longer, it also increases the number of years that we consume medical care. It should be obvious that the elderly generally consume more medical care services than the young. As the baby boom generation approaches their golden years, this too will place added stress on our health care providers. The aging "problem" (while it is a contributor to rising demand) is really not a problem as much as it is a tribute to the successes of our health care providers and medical technologies. This "problem" is the result of a health care system that works relatively well.

A second factor affecting the need for health care stems from the risky lifestyle choices of some members of society. Risky behaviors (such as smoking, drug abuse, and gang membership, to name just a few) result in a heavy burden on our medical care system. While these problems will always be with us, we must be careful that our public policy on health care does not encourage these risky activities. In politics there is a well-proven rule of thumb which states, "Subsidize an activity and you will get more of it; tax an activity and you will have less of it."

Make no mistake — universal health care makes the health-conscious taxpayer pay for the excessive medical needs of those who choose not to protect their health.

In many industrialized countries with government-run health care systems, drug abusers and prostitutes are provided plentiful and free medical care (at taxpayer expense), while many elderly and disabled are denied medical procedures because they are less productive members of society. If you think that this dangerous policy

can't happen here, you should spent some time studying some of the health care reform packages being proposed in Washington… it may very well happen here.

The third factor placing high demand on our health care delivery system may surprise many readers. In addition to serving the needs of Americans, our health care providers are also providing care to many residents of other countries. Of primary significance are Canadians, many of whom travel to the U.S. for medical services.

Due to the geography of Canada, most Canadians live in the southern third of the country and can travel to the U.S. in a short amount of time. Because of Canada's socialized health care system, many Canadians face long waits for medical procedures that are readily available in the U.S. For example, the wait for a pap smear in most areas of Canada is 5 months, and the wait for hip replacement surgery is about 18 months. The result is predicable: many Canadians, especially middle and upper income families, find it tempting (even necessary) to come to the U.S. for care. These people come to the U.S. and pay full price for the services of our doctors, clinics, and hospitals instead of utilizing the nearly "free" Canadian medical care that they have already paid for with their tax dollars. In some cases, the Canadian government will pay part of the bill for the U.S. hospital visit, but many Canadians come knowing that they will pay much, if not all, of the cost.

How significant is this medical border crossing? While precise figures are not available, some sources estimate that as many as 25% of Canadians come to the U.S. for a significant portion of their medical care. These are important things to remember when someone tells you that the Canadian system is desirable because they have lower per capita health care costs.

The fourth significant factor causing higher demand for health care stems from the increased dependence on third party payers (health insurance). As more and more people obtain comprehensive health insurance, we have fewer cost-conscious consumers when it comes to buying medical care. This is true of both private insurance and government insurance. I have to confess that our family is more likely to go to the doctor when we have met our deductible — knowing that our insurance will be paying all, or most, of the bill. This is human nature, and it is a very good reason why universal comprehensive health insurance will significantly increase demand for medical care.

Some argue that over-utilization can be prevented as long as there is a small co-payment required of the insured with each doctor visit. Co-payments do prevent some over-utilization, but for most people, a $5 co-payment is a very small discouragement when the consumer perceives that they are getting a $40, $50, or $60 visit for their five dollars.

A local college professor who teaches finance has frequently been quoted as saying, "Insurance is best when it covers the unlikely." This is sound advice that applies equally well to all types of insurance. When insurance begins to cover likely and routine expenses, it is never a smart economic decision. Low deductible, comprehensive coverage encourages people to over-utilize services. This increased demand results in upward pressure on medical prices.

Imagine, for a moment, what would happen if everyone's auto insurance covered routine maintenance like oil changes and wiper blades. You could just go to your mechanic, have the work done, and the mechanic would be reimbursed by your insurance company. Mechanics would certainly be very busy. In fact, I can imagine that a system such as this would improve the profitability of an auto shop to the extent that many new shops would open up, and existing shops would hire more mechanics.

Now imagine what would happen if we passed a law that limited the supply of mechanics. Certainly the cost of auto repair and the cost of auto insurance premiums would go through the roof. Sound familiar?

When families purchase only catastrophic health coverage and pay for other health care costs from their own pockets, studies show that overall health expenses plummet.

We need to preserve people's choice to purchase any type of insurance they desire, but unfortunately our tax code encourages the purchase of low deductible health insurance by employers. Many employees covered by these plans would likely choose higher deductible insurance (or simply major medical insurance) were it not for the fact that the employer can provide this benefit tax-free.

Health insurance is an important and necessary part of any good health care system, but health insurance, like all insurance, is only cost effective when it covers unlikely events like major surgeries or illnesses. Our present government policy encourages employers and consumers to make insurance purchase decisions that

> "If we don't do anything to increase the supply of medical care… then the only way to reduce cost is to artifically cut off demand (rationing)."

would normally be unwise. The end result is that millions of consumers have no desire to spend their health care dollars wisely, and many are encouraged to over-utilize the system. Should we be surprised that health care prices are rising?

What will happen to demand — and subsequently to prices — if we pass public-financed comprehensive universal health insurance for everyone?

PART THREE: Is Rationing In Our Future?

The concept of "rationing" is somewhat foreign to most Americans. Sure, some may remember rationing of gasoline and other strategic materials during World War II, but most of us have no concept of how difficult life can be when a vital product or service is rationed by the government. Nevertheless, unless enough Americans object, we will be under a rationing system for our health care within a few short years. If you think that health care rationing won't happen in American, please read on.

The early Clinton plan is brazen enough to implement rationing and to call it exactly that. However, I suspect that before this legislation—or any similar legislation—is passed, all references to rationing will be given more acceptable names. It might be called "managed allocation of resources" or any number of other euphemisms, but in principle, the result will be the same: rationing.

In a recent article in the *Journal of the American Medical Association,* David Orentlicher (a medical doctor and attorney) writes:

"As the United States moves toward a system of universal access to basic health care benefits, it is clear that not all medically beneficial treatments will be provided. While there is a good deal of wasteful health care spending, most commentators believe that sufficient cost savings cannot be achieved without some restrictions on useful services."

This conclusion should not surprise anyone who has read the first two articles in this series. Since the supply of medical care in America is being artificially limited, and since demand is increasing, price increases are the natural result. If we don't do anything to increase the supply of medical care (and none of the current proposals do), then the only way to reduce cost is to artificially cut off demand (rationing).

The evidence that any form of universal health care (socialized medicine) will result in rationing is overwhelming. First, every country that has adopted any form of national health care or universal health care has made the rationing of services part of their system. Second, those promoting universal health care in America readily grant that rationing will be necessary. Third, even our current publicly-funded health programs for the indigent, elderly, and disabled, limit necessary and beneficial care.

Fortunately, under our current (non-universal) system, only the government payments for medical care are rationed. This means that a government decision not to provide a particular medical procedure does not prevent the patient from finding outside funding for the cost. In our present system, friends, family, charities, and other civic-minded groups can "chip in" to pay for the necessary service. This would not be the case under most universal health care programs, which would actually ration the medical care itself. Under these proposals, certain procedures would be unavailable to certain individuals regardless of their ability to pay.

While this is not a very pleasant picture for anyone, it is especially bleak for the disabled. An inevitable result of rationing is that society (government) will have to decide which procedures will do the most "good" and which patients will "benefit" most from the medical care. The result is that health care dollars will go disproportionately toward the young and able. The experience of the industrialized countries of Europe supports this conclusion. Not only are the disabled and elderly refused treatment that is available to younger or non-disabled patients, but these systems encourage those with disabilities to volunteer for euthanasia (mercy killing).

In Holland, for example, doctors suggest suicide to non-terminally ill debilitated patients. The *Washington Times* has reported that "voluntary euthanasia" is a common and

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accepted practice in the Netherlands. According to the *London Sunday Observer*, euthanasia is administered to people with diabetes, multiple sclerosis, and rheumatism. Articles in British medical journals have reported that cost containment is the overriding goal of most European medical systems. There is no better way to contain costs than to eliminate those requiring significant amounts of medical care.

In America we have gone to considerable effort to prevent discrimination against the disabled. Congress has passed many laws attempting to protect the rights of the disabled, including the recent Americans With Disabilities Act (ADA). Despite all of these laws, however, many legal and medical experts believe that the coming health care rationing will allow methods of rationing that would make it very difficult for some disabled to receive certain types of medical care. One of these experts is David Orentlicher, who is quoted above. In his recent article, he discusses many of the legal issues relating to the Americans with Disabilities Act and health care rationing. He makes a strong case for the view that ADA would probably not prevent the adverse impact of rationing on the disabled and elderly.

As discussed in parts one and two of this series, the real solutions to the high cost of our medical care involve increasing the supply of health care providers and reducing reliance on third party payers. Unfortunately, the major media and our elected officials ignore this important issue.

When we look at the health care systems of Europe and Canada, it is clear that their systems are inferior to our own. Why then do our politicians push us to adopt plans like the systems in Canada and Europe? The problem with the entire health care debate is that everyone is looking to a government-mandated, government-run system as the solution to a "crisis" that may not be as bad as the proposed solutions.

We should remember that everyone suffers when care is rationed, but certainly the aged and disabled have the most to fear.

PART FOUR: The Big Squeeze!

Charities & Non Profit Organizations are Being Squeezed out of Health Care. Every year in America, non profit organizations and charities raise hundreds of millions of dollars to help provide medical care and medical devices to the indigent. These groups include churches, service clubs, foundations, professional associations, and a variety of other charities. They are able to provide funds (and—as a result—medical care) to countless numbers of low income people without the permission of any government agency. But under the leading health care "solutions" being proposed in Congress, many of these organizations will be put out of the charitable health care business.

Raise the money, buy the care.

In our current health care system, as with almost every area of our economy, money can buy almost any product or service deemed necessary by the consumer. While this is a frightening thought to those with thin pocketbooks, at least this system provides an open door through which charities can provide assistance. As the director of an organization that devotes a portion of its budget to purchasing medical devices for those with limited income, I am concerned about high health care prices, but I am even more concerned about health care availability. Higher prices may require us to raise more money to help someone, and higher prices may even reduce the number of people that we are able to help, but at least we can still help. However, if the health care is unavailable or if it is rationed, no amount of fundraising will buy the necessary services for our clients.

Under these proposed health care plans, there will be two types of health care: affordable care and no care. If the government makes health care available through its "rationing" plan, it will be affordable. But if it is on the wrong side of the government's coverage charts, then it will not be available at all, regardless of cost.

Where does this leave our charitable efforts? It means that some organizations will close their doors. Others will simply redirect their efforts away from health care to other activities. This will inevitably leave more people without care, and it will greatly increase the financial

burden on government as it tries to fill the gap. As government does more in a specific area, private charities will generally do less.

PART FIVE: Cost vs. Availability

While visiting a retired relative recently, I picked up a magazine off the coffee table. It was a well known and widely circulated publication that is received by millions of retired Americans. One of the articles featured a survey that asked senior citizens in many industrialized countries to state their greatest health care concern. A high percentage of seniors in America stated that the cost of health care was their greatest concern. Seniors in other countries, however, didn't seem to find cost to be a problem at all.

The article pointed out that the U.S. is the only industrialized country lacking some form of universal socialized health care. This observation is quite correct. The fact that the government pays for much, if not all, of people's health care in these other countries (Europe and Canada) would certainly explain the survey results. Conspicuously absent from the article, however, was any mention of what the European and Canadian seniors felt was their greatest health care concern. However, based on what we know about these systems, we can confidently conclude that availability and waiting times would probably be at the top of the list for residents in these countries.

If you can't get medical care, does it really matter whether it is because of cost or because of rationing? The only way to make more medical care available to some without taking it away from others is to have more providers in the system.

PART SIX: Is Health Care More Important Than Freedom?

The trend in modern society is toward the pursuit of more and more security. We want guaranteed employment, guaranteed retirement benefits, and guaranteed health care. The pursuit of these securities is a noble personal and family objective, as long as it remains a private pursuit. But as soon as our attempts to gain security enlist the use of government, our society sacrifices freedom of choice. Our grandparents called that freedom "liberty."

In the public sector, any attempt to guarantee security will come at the expense of someone's liberty. Government cannot give to one person without taking away from another. Both the "giver" and the "getter" lose freedom of choice in the process. The "giver" loses the ability to decide how to spend their money, since it is taxed away in order to fund health care services for the "getter." And since a government that funds a program has the right to control how the funds are used, the "getter" loses the ability to make decisions about how, when, and where to purchase their medical care. Under a universal health care system, most Americans become both "givers" and "getters," and are denied personal liberties on both sides of the system.

The irony of the whole political process is that the more we strive for economic security, the less of it we have. There are some widely accepted rules of economics that account for this (which I won't delve into here), but we can see evidence of this principle throughout America and the world.

The efforts of Europe and Canada to guarantee universal health care, as discussed in our section on rationing, resulted in more health care security for some but far less for others. These nations have traded a health care system that previously limited access based on ability to pay for one that now limits access based on government rationing and scarcity.

Nothing in these programs produced any more health care—they just changed the allocation of existing resources, and charged the taxpayers for the bureaucracy necessary to accomplish the task.

Here are some questions to ponder:

Should we have the freedom…

… to choose our own doctor?
… to chose the type of treatment we desire?
… to choose how we pay for our medical care?
… to purchase only high deductible, catastrophic health insurance?
… to purchase low deductible, comprehensive health insurance?
… to choose not to purchase health insurance at all?

Personally, I want the freedom to make each of these decisions. As an individual, I may not always make the best decision, but my motives will always be pure. I will learn from my mistakes because I will suffer the consequences of them. And no one else will suffer for my mistakes. Can the same be said of any mandatory public-funded system?

PART SEVEN: What Should Be Our Public Policy on Health Care?

1) Modify our government policies that limit the supply of health care providers.

We need more doctors, more nurses, and more trained health technicians — not less. However, our current system allows the supply of these important professionals to be artificially capped.

2) Review government regulation of the health care industry to reduce unnecessary and duplicative regulations and paperwork.

In a recently published book, Edward Annis, M.D., former President of the AMA, claims that prior to Medicare, the average physician spent one-fifth of his or her time caring for the poor. But today, the average physician spends one-fifth of his or her time on regulatory paperwork.

Experts disagree as to how much government paperwork adds to the cost of medical care, but even the most avid proponent of the government regulation will admit that at least 20% of health care costs are for government paperwork. Even President Clinton in his State of the Union Address in 1993 admitted that regulations add over 20% to American's health care costs, and some sources claim that the figure is closer to 35%.

The only way to reduce these costs is to have less government involvement in health care. More government involvement in medicine will only increase paperwork and regulatory costs.

3) Health insurance needs to cover less not more. Health insurance, like any other insurance, should cover the "expensive and unlikely" costs, not the "affordable and likely" costs. We need to eliminate tax incentives that encourage employers to buy insurance coverage for "affordable and likely" costs. It is this "over-insurance" that encourages consumers to over-utilize services, thus placing upward pressure on medical care prices.

When government provides full coverage for all, or part, of Americans, it creates the same upward pressure on prices. The result of universal health insurance will be a rapid rise in medical care prices. The only way to curtail these rising costs will be to reduce demand by rationing care.

WHAT CAN ONE PERSON DO?

1) Write to your representatives in the U.S. Congress and the U.S. Senate. Let them know that you oppose socialized medicine in any form. Encourage them to explore the real solutions outlined above.

2) Inform your friends and associates about the dangers of socialized medicine and rationing. Explain how rationing always discriminates against the disabled and the elderly. Explain that health care providers and individuals should decide who gets medical care — not the government. Provide them with a reprint of this article that we have published on this subject.

3) Write a letter to the editor of your local newspaper explaining just one or two of the issues discussed in these articles.

PART EIGHT: The Danger of Compromise

As discussed in previous sections, the leading health care reform proposals coming out of Washington D.C. contain some very radical and very undesirable features. These proposals are certainly dangerous to the health of Americans. Hopefully Americans will wake up, and these proposals will be soundly defeated. Unfortunately, the media has convinced most Americans that government action of some kind must be taken. So even if the Clinton proposal is defeated, there will probably be some "compromise" legislation that will pass. This "compromise" health care reform may only be half as bad as the Clinton proposals, but it will still ignore the real causes of our problems and will either fail to eradicate escalating costs, or it will ration access to necessary and beneficial care.

There is a well-used political strategy called the dialectic. Most readers may have used one or more variations of this technique in business negotiations. This strategy works like this: Let's assume that your 13-year-old wants a $5.00 raise in his allowance. Let's also assume that your teenager knows that you probably won't give him as much as he asks for. Instead of asking for five dollars, the astute teen asks for an eight dollar raise, hoping that, after some discussion and debate, you will compromise and provide a raise in the five dollar range. Of course, the teenager would love an eight dollar raise, and if by reason of some temporary insanity you feel generous and consent to the initial request, you will get no complaint from your teenager.

The shrewd teen also knows that it is easier to obtain a lavish allowance in stages rather than all at once. Each compromise raise in allowance places the teenager closer to the ultimate goal.

Politics is no different. Those who want draconian proposals like the Clinton plan will strive for their goal relentlessly, but if it looks like their objective is out of reach, they will gladly negotiate a compromise that gives them part of what they want.

It is perhaps the "compromise" health care plan that is more difficult to defeat, and therefore more dangerous. After months of political battle, the opposition to socialized medicine will become fatigued by the issue. And when the compromise legislation shows up, it will receive much less opposition than would have been the case had it been the first and primary proposal.

Of course, if it passes, the less objectionable compromise legislation will be amended and expanded little by little. Within a decade, it may bear a surprisingly close resemblance to the original proposal, which was rejected as being too expensive, too restrictive, and otherwise undesirable.

Those who are concerned about issues like freedom of choice in health care, government spending and deficits, and the rights of the disabled and elderly to access health care, should oppose socialized medicine in any form. We should accept no compromise that enables government to restrict our freedom to choose providers, facilities, or treatments. We should accept no compromise that ignores the shortages of many types of health care professionals. We should accept no compromise that frees people from responsibility for their poor lifestyle choices. We should accept no compromise that crowds private charities out of providing health care. And last, but not least, we should accept no compromise that moves our country toward systems that have failed in the rest of the world.

In the words of Ben Franklin, "They that can give up a little essential liberty to obtain a little temporary safety deserve neither liberty nor safety." IPS

15 YEARS LATER: *The Socialization of Health Care*

We should not make the mistake of assuming that the socialization of health care is a Republican vs. Democrat issue. Socialist thinking has permeated both political parties — and much of modern Christianity as well. A recent cover of Newsweek magazine boldly proclaimed: "We are all socialists now." Unfortunately, this isn't far from the truth.

It is ironic (but not surprising) that the most significant steps toward more socialism in medical care came not under the Clinton administration, but under the administration of George W. Bush. In 2003, Congress passed, and President Bush signed, the Medicare Prescription Drug, Improvement, and Modernization Act, which expanded public funding and government control of America's health care.

In 2007, United Press International quoted David Walker, then U.S. Comptroller General, as saying that this act (Medicare's prescription drug program) might be the most financially irresponsible U.S. legislation passed in 40 years. This bill was commonly recognized as the single largest federal entitlement program since Lyndon Johnson's Great Society.

Bill and Hilary Clinton did not immediately achieve all of their health care objectives, but as was predicted in the 1994 article (our lead article for this issue of *Principle Perspective*), the proposed Clinton plans paved the way for compromise and then gradual steps toward their goal. The boldness of the Clinton health care effort made it possible for a Republican president to do what Hilary and Bill could not do, because the prescription drug plan seemed tame by comparison. This is a classic example of the dialectic strategy at work — thesis, antithesis, and then synthesis. These steps, if repeated, make the radical seem less radical — even reasonable.

Americans should not accept any "victory" in a watered-down, compromise version of a health care bill. Any and all movement toward the expansion of government involvement in health care should be emphatically opposed.

Proponents of limited government and free markets need to go beyond defensive strategies. It is not enough to work to stop the further advances of socialism; instead, proponents of free markets need to become aggressive in promoting the repeal of older socialist programs. No mater how good the defense, no sports team ever wins without at least some offense. IPS

TITLES OF NOBILITY? *Czars in America*

Drug Czars, Engergy Czars, Regulatory Czars, Urban Czars, and now a Cyber Security Czar… These are not titles of 19th century Russian monarchs. They are 21st century American government officials. An analysis article from Reuters news service says that "there are upward of 20 such top [U.S.] officials, all with lengthy official titles but known in the media as czars."

The word "czar" is derived from the word Caeser, which means emperor or king. In centuries past, many eastern European and Asian monarchs either referred to themselves as czars, or were given this title in common usage.

Why would a nation such as ours, a nation of free people, jealous for liberty, allow government officials to operate with such titles?

> "No Title of Nobility shall be granted by the United States…"
>
> Article I, Section 9,
> United States Constitution

Maybe I'm making much ado about nothing. Some would argue that these people have other official titles apart from being a "Czar" or that these people aren't really kings. It might be true that they have other official titles, but so many people — including members of Congress, administration officials, and the media — refer to them as czars. They might not be literal kings, but some of them are certainly wielding unconstitutional power.

In America, we are slowly but methodically increasing the number of these Czars. My first recollection of the use of the word czar as a title was in 1982, during the war on drugs, when politicians and the media began to refer to the Director of National Drug Control Policy as the "Drug Czar." At the time, it seemed slightly humorous, and no one seemed to object to the term, although some did object to this expansion of federal government authority. Now we have dozens of Czars — and unless the citizens object, there will be more to come.

The truth of the matter is that words have meaning. We may argue about whether language precedes or follows policy, but regardless of whether our acceptance of monarchical language is a cause or a result of changes in our government, it is clearly an indication that we have lost our fear of unbridled government power. As America allows more and more power to be centralized in the executive branch of our government, we have also become more accepting of titles that represent nobility and monarchy. Instead of centralizing power, we should be decentralizing — and we need to adopt language (and titles) that reflect decentralization. Normalizing titles of kingship or monarchy into our lexicon is a dangerous thing. Let's eliminate the use of words like "czar" — and while we're at it, let's eliminate all of these unconstitutional positions that try to claim such titles. IPS

Summer Vending

At an organization like IPS, educational efforts generally take the shape of large-scale classes or conferences, but we also strongly believe in the value and importance of small-scale, personalized, one-on-one education. One of the best places to engage in these concentrated, conversational efforts is a homeschool convention. Over the years, we have found that these conventions — typically full of energy and attended by people who are very open to being educated — prove a superb place to plant seeds that we hope will bear fruit in the months and years that come. During the summer of 2009, we have had several opportunities to vend at important homeschool conventions, including the Valley Home Educators convention in Modesto, which is one of the largest in the state. Please join us in praying that the seeds we were able to plant at these events will be watered, cultivated, and will bear fruit for the kingdom of Christ.