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The Two Alternatives for Health Care Policy

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National health care costs have been growing faster than the economy for close to 100 years. But that cost growth accelerated over the past 50 years, soaring from 5% of GDP in 1960, to 10% in 1985, to 17% in 2009. That is the highest proportion of output devoted to health care of any country in the world, by far. Second place France comes in at 11.2% of GDP, followed by Switzerland (10.7%), Germany (10.4%), and the United Kingdom (8.7%). The OECD average is 9%.

Since we still have the largest economy in the world by far, that means we spend far more on health care than any other country in the world. U.S. health costs totaled \$2.5 trillion in 2009, more than the entire economies of every other country in the world except China, Japan, Germany, and France.

Per person, we spent \$7,538 on health care in 2008, again higher than any other country by far. That was 50% more than the second most, Norway, at \$5,003, with Switzerland in third at \$4,627. Germany only spent half as much, at \$3,737 per person, and the United Kingdom less than half at \$3,129. The OECD average was less than half as well, at \$3,060.

These trends are expected to continue. CBO projects that on our current course, by 2040 health care costs will consume close to one-third of GDP.

The root of these rapidly rising health costs is what economists have called the Third Party Payment problem. The great majority of health costs in America are not paid by the patients themselves. There is almost always some third party paying the bills, either an insurance company, an HMO, or the government through programs such as Medicare and Medicaid. Indeed, in 2008, 84% of health expenses were paid for by private health insurance, Medicare, Medicaid, CHIP, or other public spending.

Try this thought experiment. Consider sending your teenage daughter to the mall on a Saturday with a debit card for a bank account with \$1,000 in it. Tell her that what she doesn't spend today she can keep for the future, with interest, to spend later. Then consider sending her to the mall with Uncle Sam's credit card. Tell her you effectively have already paid for whatever she might charge through your income taxes. How do you think the magnitude of what she purchases would differ in these two scenarios?

The fundamental problem, of course, is that with a third party paying the bills, the consumer, or the patient, has no incentive to control costs. In formal terms, the consumer has an incentive to spend until the marginal benefit of additional spending, or additional health care is zero, so different from an efficient market, where consumers spend until the marginal benefit is equal to the marginal cost. In more colloquial terms, this means consumers have the incentive to spend on health care until it hurts.

To make matters worse, consumers lack expertise in health care, and make their health care purchases on the advice of their chosen doctors and specialists, who not only also have no incentive to control costs, but, rather, have a direct financial interest in them spending more. The consumer doesn't even have an incentive to shop for the lowest cost care for what he does decide to consume.

This means, in turn, that health care providers have no incentive to compete to reduce costs, since consumers and patients are not making their health care decisions based on costs. They are making their decisions based primarily on quality, and secondarily convenience. That is why the American health care system produces far and away the highest quality health care in the world, resulting from highly effective capitalist competition, and traditional Yankee ingenuity in producing the latest and best innovations.

This also explains why new medical technology increases costs, while in every other field new technology drives down costs. Since in American health care there is only competition to maximize quality, regardless of costs, developers and innovators of new medical technology are focused primarily on increasing quality regardless of cost.

The only solution to this problem is to unite the decision over what health care to purchase and consume with the economic responsibility to pay the costs, so costs can be weighed against benefits in health care consumption. There are two alternative ways to do that.

Either the third party payer is given the power to decide what health care the consumer or patient is allowed to consume, in which case the third party payer weighs the costs of the patient's health care against the benefits to the patient from that health care. Or the patient is given market incentives to consider the full costs of the health care he chooses to consume, in which case the patient weighs the personal benefits of his health care against the costs of that care.

Most countries have chosen the former alternative through socialized medicine. With the government taking primary responsibility for paying health expenses through its taxpayer financed health programs, the government takes primary responsibility for deciding what health care its citizens are allowed to consume and when. The government then decides to what extent each individual's health care is worth the costs.

This introduces its own perverse incentives, particularly to sacrifice to broader political calculations the interests of the sickest and most costly, always a small minority not nearly fully aware of the scope of possible medical alternatives. With the government and politics ultimately deciding who gets paid how much for what health care, incentives for investment to develop new medical technology, innovation, and breakthroughs are badly hamstrung. Finally, this system

raises troubling moral issues, with the government effectively deciding in place of citizens whether their health care is worth the costs, and consequently who should live and who should die.

Though initially subtle and opaque, Obamacare creates the framework to take America down this road.

The alternative has been dubbed Patient Power, after the path-breaking book of that name by free market health guru **John Goodman** published by the Cato Institute in 1992. The classic example of such policy is Health Savings Accounts (HSAs).

The concept behind HSAs is to start with an insurance policy with a high annual deductible, in the range of \$2,000 to \$6,000 in today's products (the higher the better). Such high deductibles, of course, reduce the cost of the insurance substantially, with the savings then kept in the savings account to pay expenses below the deductible. Generally, after one healthy year with little or no medical expenses, the patient by the second year would have more than enough in the account to cover all expenses below the deductible. Unspent HSA funds can be used for health expenses in later years, or for anything in retirement.

This transforms the incentives of third party payment. For all but catastrophic health expenses, the patient is essentially using his own money for health care. Whatever he doesn't spend he can keep. So the patient will try to avoid unnecessary care, and look for less expensive care and alternatives for what he does need.

In turn, since patients would now be concerned about controlling costs, doctors, hospitals and other health providers would now compete to control costs, as well as maximize quality, as in all normal markets. This competition would become more intense and effective the more widespread HSAs and similar incentives become.

These incentives would flow all the way through to the developers of new technologies. Since both patients and health providers are now concerned with costs, technology innovators will now have incentives to develop technologies that reduce costs, as well as improve quality.

Experience with such incentives shows that they do have powerful effects in controlling costs. A sophisticated RAND study conducted in the early 1980s demonstrated that when patients pay for health care out-of-pocket, as with a HSA, they do reduce their health spending substantially. Yet, they are judicious in how they do it, with no apparent negative effects on health. Indeed, studies show that patients with HSAs actually spend more on preventive care than others, perhaps because they have economic incentives to preserve their future HSA funds, as well as their future health.

HSAs can be expanded throughout the health care system. Workers can be allowed the freedom to choose them in place of employer provided coverage, the poor can be allowed to choose them for their Medicaid coverage, seniors can be allowed to choose them for Medicare.

Similar policies would involve providing the poor through Medicaid with designated sums for the purchase of insurance coverage in competitive markets, resulting in incentives for cost saving choices among health insurance alternatives. That can be done with employer provided health insurance as well.

The same can also be done for Medicare, as House Budget Committee Chairman Paul Ryan has proposed. A similar approach for the drug coverage of Medicare Part D proved quite successful in controlling costs.

By contrast, President Obama's approach to Medicare emphasizes again the other alternative of expanded government control over the health care provided to seniors under Medicare through his Independent Payment Advisory Board, ominously exempted from democratic control. This is one of the most important reasons why Ryan's Medicare reforms are actually better for seniors than Obama's approach to Medicare.

With more creativity, we can extend these market incentives even to catastrophic care, particularly high health expenditures in the last year of life, which many people find wasteful. Consider a patient with a deadly cancer that would cost a million dollars to treat, with a substantial probability of failure nevertheless. Why not allow the insurer to offer the patient to split the savings if the patient will choose to forego the care?

Patients may decide they would rather leave the half million dollars to their families than spend it on heroic medicine, which may entail a lot of physical pain and suffering, with highly compromised quality of life on the other end at best. The insurer should be free to offer the patient as much of the savings as possible.

The patient must be completely free to make this decision, with no power in the insurance company to force it. But empowering the patient to weigh the costs against the benefits and make this decision about his own health care would be morally unobjectionable. Indeed, only the patient can morally make this decision for himself or herself, not some third party government or insurance company bureaucracy. And fundamental economic logic tells you somebody should be making this decision.

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