

## Health Care: How Much? Who Pays?

*The health care issue receded somewhat in the public's consciousness after the rejection of President Clinton's proposals in 1994, by the then Democratic Congress. It appeared that once Americans had a look at what a radical re-structuring of health care delivery might look like, they decided that they preferred to keep things essentially as they are and to focus on incremental changes.*

*The fact is that our health care is the best in the world. The latest and best technologies and treatments are widely available here, and virtually no one in dire need is denied care. This is not to say that all is well, only that the major problems are not medical but economic. Most of the latter reflect, not a failure of markets, but existing government interventions. This is evident from an examination of the various ways health care is bought and paid for.*

It has been only during the past 100 years or so that patients stood a better than 50-50 chance, on average, of genuinely benefitting from an encounter with a physician. Our forebears were fortunate that the human body tends to heal itself. For most of history, doctors' prescriptions were sometimes beneficial, sometimes harmless, and sometimes worse than no treatment at all — blood letting, for example.

Various public health measures (see the box on the next page) have made it far less likely that one will contract many historically devastating diseases and disorders in the first place. More to the point, there now are many situations in which medical attention clearly makes the difference between life and death. The development of medical technology (anesthesia, antiseptic surgery, drugs and antibiotics, etc.) has greatly increased the efficacy of medical attention.

Healthy people no longer need die from infections, gaping wounds, appendicitis, etc. There are now very specific and effective treatments for these and a host of other traditionally lethal maladies. Many of these treatments were very expensive and exotic at first, but became relatively inexpensive and routine as they became widely used. However, clearly efficacious treatment restoring good health and even preserving life itself accounts for only a fraction of health care spending.

Most health care spending is for the relief of suffering, and in these situations there are usually several alternative treatments that can be employed. The notion that there is a single "best" course of treatment for every ailment and every individual, which is often implicit in discussions of health care issues, is wrongheaded. Even if it were so, as might be determined with hindsight after mistakes have been made (at an autopsy, for example), the related notion that the "best" treatment can be determined in advance is ludicrous, especially when the determination is to be made by anyone other than the patient and the attending physician.

Even though most people understand that, say, the President of the United States will receive better and more thorough health care than the average citizen (for the same reason that Air Force One undergoes more rigorous maintenance and safety inspections than commercial airliners), discussions of health care often implicitly assume that the care provided and received is somehow uniquely determined by purely medical circumstances. This leads to a focus on high prices and/or the fact that Americans devote a larger proportion of their output to health care than any other nation.

### *Costs vs. Spending*

Costs and spending are not necessarily related. Caviar costs a lot, but spending

on it is low, as it is purely a reflection of consumer preferences. Medical expenses, on the other hand, reflect a variety of other influences. Medical costs are boosted in this country because many elaborate and expensive procedures are widely available here that are not elsewhere. In addition, our health care system is burdened by excessive paperwork and tort liabilities of providers. A variety of other factors, such as licensure or patent protection of innovations, boost prices. Moreover, our health care industry carries much of the world's burden of research, which is embedded in prices.

Spending on medical care is similarly influenced by the availability of elaborate and expensive procedures, but it also reflects demographics, especially our aging population. Above all, our spending is high because, unlike most items of consumption, the decisions are often made and paid for by someone other than the consumer. But this is not unique to the United States. Our high total spending relative to other countries mainly reflects our income — spending on health care rises with income. In poorer nations, outlays for food and shelter account for higher proportions of spending.

In short, high costs and spending are not simple issues. We spend a lot on health care because, in the final analysis, we want it. Most Americans would be likely to reject solutions that would limit either the availability of health care or the advance of medical science. Useful reforms are most likely to be found after examining the various ways health care is bought and paid for and, specifically, how government intervention has distorted these decisions.

### *Fee For Service*

You get treatment, you pay the bills. For most of human history, this is how health care has been provided.

Fee for service still accounts for a major component of health care spending in the United States. People buy non-prescription items in drug stores. They buy vitamins and nutritional supplements and they consult "alternative healers" (homeopaths, osteopaths, *et. al.*). They have dental work and cosmetic surgery done and

they visit eye-doctors and buy spectacles. They see counselors and psychotherapists of various disciplines. Americans pay for most of these items out of their own pockets. If they cannot get, or do not choose to buy, medical insurance, they pay the bills themselves. If their insurance carries a deductible, they pay bills up to that deductible. All such spending is included in the Nation's total health care outlays.

From an economists' point of view, fee for service has an enormous advantage over alternatives: purchasers must evaluate outlays against all other possible uses of their money. Hypochondriacs might spend a lot on health care and stoics very little, but their spending reflects their own particular wants and needs.

Fee for service, it has long been argued, favors the "rich." The "rich," of course, are always favored in markets with

uniform prices, simply because they can buy more or better quality of whatever is for sale. But, traditionally and even today, doctors who bill patients directly usually do so on a "sliding scale," *i.e.*, according to their (informal) understanding of their patients' ability to pay. In addition, medical practitioners and hospitals have always had to write off more of their billings as "bad debts" than most other enterprises. These practices, together with charity hospitals and clinics, meant that the "poor" were never completely excluded from care.

A second objection to fee for service, especially after efficacious procedures became more complex and expensive, was that most households and individuals are hard-pressed to pay large and unpredictable medical bills. This led to the development of health insurance.

### *Health Insurance*

Insurance is designed to spread risk, by exchanging a relatively small, but certain, payment to provide compensation in the event of a large loss that has a relatively small likelihood of occurring. Insurance policies that pay for major surgery and or hospitalization, which relatively few people undergo in a given year, were thus a normal market for underwriters to enter.

If policies are written for groups of people, say, all the employees of a given company or all the members of a fraternal order, the premiums can be lower than for individuals who purchase policies for themselves. This is because underwriters, not unrealistically, assume that groups of policyholders selected by criteria other than their desire to buy health insurance will be healthier, on average, than groups of policyholders having only a desire to buy health insurance in common.

### *Enter Government*

The Federal government operated military hospitals and larger cities often operated municipal hospitals for the indigent. These provided health care at little or no charge for a relatively small portion of the population. However, and curiously, the effect of the first sweeping government intervention in health care was to make it less affordable. This was prosecution of unlicensed physicians.

As with most licensure statutes, this was touted as a measure to protect the public, but its major effect was to protect and boost the incomes of incumbent providers, by stifling competition. This helped to accomplish a long-stated goal of the medical establishment — limiting the number of physicians — and it reinforced the dominant role of doctors in health care. What the doctor said went. Even today expensively educated individuals can be found performing (and charging for) what are essentially repetitive and artisan-like tasks that less "qualified" people could do equally well or even better.

In any event, the notion that licensure protects the public is belied by the notorious reluctance of medical associations to genuinely discipline their members, even those who are demonstrably incompetent or dishonest. We will not speculate on how health care delivery might have evolved in the absence of licensure, but it is safe to say that physicians would be paid less and other types of professionals would be more involved.

The second sweeping government intervention was to allow deductions for medical expenses in calculating income subject to tax. The effect of this was lim-

### **Public Health**

Readers may be excused if they conclude from the accompanying article that we do not believe government has a useful role to play. We do believe that government intervention in health care has been at the root of many of its problems. On the other hand, although there are occasional stumbles (remember President Ford and the "swine flu"), government spending on public health measures can, and does, provide good value for money spent. Public health programs play a very important, and often unseen and unappreciated, part in attaining and maintaining our current levels of health and well-being.

Wholesome food and drink perhaps heads the list. Strict libertarians might object to regulations such as those mandating enriched flour, iodized table salt, vitamin D milk, etc., but there can be little doubt that nutritionally-related disorders, such as rickets, pellagra, or goiter, have become virtually non-existent at a very minor cost. Water treatment systems and regulations have made cases of intestinal parasites (and worse) quite rare among U.S. residents. Dysentery is a leading cause of death world-wide, especially among infants, and cholera has recently been reported in some "third world" cities. Only eternal, and largely unsung, vigilance prevents outbreaks of such water-borne diseases here.

We owe the virtual disappearance of many communicable diseases to public health programs. Mass inoculations, the tracing of patterns, quarantines, warnings of dangers, are things that civil servants, in the truest sense of the word, can do well, as long as they do not become politicized.\* As the world becomes increasingly interconnected by travel and trade, such efforts may become increasingly important.

\* The "war" against AIDS may be an example of politics intruding on useful efforts. Perhaps because the warriors feared that they would lose funding if the close links between the transmission of the HIV virus and behavior that most citizens find repugnant was stressed, vast sums have been spent warning against an outbreak in the general population. The onset of this outbreak keeps receding into the future. Many analysts have concluded that there would now be significantly fewer cases of AIDS if these funds had been devoted to efforts on the relevant population groups.

ited as long as relatively few person were subject to the tax and when tax rates were low.

Even when the tax rate rose to confiscatory levels and most workers became subject to tax, the effect was limited to those in a position to itemize deductions and it was more significant to those in the higher brackets than those in the lower brackets. If Mrs. Gotrocks saw her psychiatrist 5 or even 10 times a week, the government would, in effect, pick up as much as 90 percent of the bill, while Joe Sixpack, if he had enough deductions to itemize at all, might only "save" 16 percent or so of the bills for his wife's pregnancy and the delivery of their child.

We will not go into a history of the tax deduction for medical expenses, which has varied considerably over the years. (At present it is limited to expenses in excess of 7.5 percent of taxable income. In the absence of income averaging over a period of years, it is of limited benefit for those who face very large medical expenses in a single year, which is presumably the rationale for the deduction.) As indicated above, the medical deduction had the quite perverse effect of favoring medical outlays of high income individuals, by making such outlays cheaper for them relative to other things they purchase.

The real mischief of the medical deduction, however, has been that it established the precedent for paying for health care with pre-tax dollars.

### ***Employer-Paid Group Insurance***

The next great government intervention in health care was to permit employers to deduct as a business expense premiums paid for health insurance for their employees, *without declaring them as income to the employees*. This has had several major consequences.

First, it created a strong incentive for such insurance to be as "comprehensive" as possible, because it meant that all medical costs covered by insurance would be paid with "pre-tax" dollars and anything not covered had to be paid out of after-tax income. As discussed above, the ability to pay medical bills with pre-tax income was otherwise available only to high-income taxpayers who itemized deductions and in recent years their deductions have been greatly curtailed.

Comprehensive employer-paid plans removed the most basic health care decision, the patient's choice of seeking medical attention, from the economic calculus. If it is "free" or only carries a nominal cost, the only reason not to go is the inconvenience and possible pain of a visit to the doctor. As result, not only did the

## **Comprehensive Insurance**

As it has evolved under the incentive structure created by government regulation and tax rules, comprehensive health insurance policies are virtually designed to increase the use and the cost of health care. Unlike other forms of casualty insurance, such policies pay for what are essentially routine and even predictable expenses.

Consider, for example, what would happen if your car insurance was paid by your employer and covered not only major mishaps but also all maintenance and even purchases of fuel and oil. How carefully would you scrutinize your mechanic's bills? How hard would you look for the best gas price in town?

demand for health care increase markedly, but the cost of providing for minor and routine health care was boosted by an extra burden of administration and paperwork.

Second, because employees with a history of medical problems, or who had dependents with problems, often encountered difficulties in enrolling in a new group plan if they changed jobs, employer-paid group plans can have the effect of "locking" employees into a given job. This had the macro-economic effect of reducing the efficiency of the labor market, by retarding the mobility of labor, because the availability of health insurance could become a major consideration for employees contemplating a change of jobs or careers. Indeed some analysts have concluded that the primary health care concern of Americans is not cost or quality, but the possibility that they will lose or be denied insurance at some point in the future.

Third, it resulted in great disparities in health care costs. A business that was growing rapidly and had a relatively young staff could provide health insurance at a very low cost. The costs for a mature and stagnant business with an aging staff could be much higher.

These disparities are even greater for health insurance purchased directly by individuals.

### ***Individually Purchased Health Insurance***

The predominance of employer-paid group plans places individuals at a severe disadvantage when purchasing health insurance on their own. There is an adverse self-selection among purchasers (sickly people are more likely to want the insurance), and many healthy young adults who do not qualify, for one reason or another, for employer paid-plans elect to forego health insurance because they do not perceive the prospective benefits of its cost

to be as attractive as the benefits of alternatives such as better housing, better motor vehicles, better vacations, etc. Thus, the very people whose participation could make health insurance more "affordable" are driven out of the system.

Moreover, individuals do not have the bargaining "clout" of group purchasers, which tempts carriers to make up from individuals what they lose on groups. Individual policies may also be far more restrictive, with total exclusions or longer waiting periods for "pre-existing conditions." Finally, and most bizarrely from the standpoint of public policy, *most individual purchasers must pay their premiums out of after-tax incomes*.

Individual health insurance is made amazingly more expensive than employer-paid group insurance by these factors. To repeat, these are largely a result of government intervention in the market for health care.

### ***Government Insurance: the Non-Solution***

We have yet to discuss what most people think of as the government's main involvement in health care: Medicare and Medicaid. The first thing to understand is that it is a perversion of language to call these programs "insurance." The costs of these programs are almost entirely paid by persons other than the beneficiaries, and there is no underwriting (assessment of risk). People are "covered" if they qualify according to age or economic status alone. This is not insurance, it is government taxing and spending.

The same would be so if, as many seem to hope, the government mandated "universal coverage" or so-called "single payer insurance," which, no matter how it is sliced and diced, would mean compelling payments from some people (taxes, in other words) and spending it on others. Even if the program were administered by private entities, rather than another Post

Office (as in the national health services of countries with "socialized medicine") the results would be the same — an eventual deterioration of service as bureaucrats struggle to contain outlays.

This is the prospect that the public saw in President Clinton's plan. The public flinched. Medicare and Medicaid do suffer from the same drawbacks as private comprehensive insurance — a divorce of health care usage decisions from a genuine economic calculus — only more so. However, for the purposes of this discussion, their main interest is how they demonstrate the utter failure of bureaucratic attempts to control costs, which has been a major goal of the programs since they were initiated. Reportedly, by 1993, Medicare alone was the subject of over 1,000 pages of laws and another 1,000 pages of regulations, as well as an amazing 20,000 pages or so of guidelines and administrative rulings.

Physicians spend as much as 25 percent of their time complying with such paperwork, and an entire consulting industry has sprung up to advise doctors and hospitals on how to best "game" the system to their own advantage. This involves techniques such as defining illnesses and courses of treatment in ways that maximize government reimbursements, and ordering tests, procedures and office visits because they are likely to be approved by the bureaucrats rather than because the patient needs them. If all else fails, health care providers can increase the fees for other patients ("cost-shifting"), which is another reason why individuals, who have the least bargaining power, often pay more for care.

In short, as has been the universal experience with price control, the bureaucrats face a losing battle with those closer to actual transactions. Piling regulation upon regulation, and guideline upon guideline, will at best produce a stalemate, until the system collapses of its own weight.

### Republican Reforms

Meanwhile, spending on these programs continues to increase at "budget busting" rates. The Republican Congress passed measures designed to retard their growth, but these were vetoed by President Clinton in this election year, claiming variously that the Republicans were "gutting" the programs or that the savings were going to be used for "tax cuts for the rich." Neither of these assertions were exact: the programs were to remain in place and the savings were to be placed in a new "trust fund" to provide for the continuation of the program into the 21st century. Clinton had previously indicated that

he well understood the need to curtail spending on Medicare and Medicaid, but for the moment, anyway, he seems to favor only a continued tightening of the bureaucratic screws on the health care providers.

In any event, it is worth examining what the Republicans wanted to do. Medicare beneficiaries would have been allowed to stay with the program as it is, or they could elect to receive a grant towards the purchase of private insurance. If they wished to purchase insurance with extensive coverage that cost more than the grant, they would have to pay the difference themselves, whereas they could keep the difference if they purchased a plan that cost less than the grant. (Curiously, this is essentially the way that the Federal Government provides health care for its own employees, including members of Congress.)

A related measure, also vetoed by President Clinton, would have been to permit individuals to establish medical savings accounts (MSAs). Funds paid into these accounts would be deductible from taxable income and withdrawals used to pay (relatively high) deductibles on health insurance policies would not be taxed. Withdrawals for other purposes would be taxable (with a 10 percent surcharge on withdrawals before age 59), and interest earned on the account would be taxable as it was earned. In addition, MSAs could be used to purchase private extended care (nursing home) coverage, which was expected to relieve some of the financial pressures on the Medicaid program.

The main Republican proposal regarding Medicaid, however, was to convert it to "block grants" to the states, which would then be allowed to determine their own eligibility criteria and benefit levels. This was designed to replace a complex morass of Federal regulations, that can grant benefits to some individuals and families that have higher incomes than others who are ineligible for benefits.

Finally, the one Republican initiative that President Clinton did sign into law was that designed to improve the "portability" of coverage, *i.e.*, to enable workers to remain continuously covered when changing jobs, regardless of "pre-exist-

ing" conditions. It remains to be seen how effective this will be in relieving "job lock" and worker anxiety regarding health insurance.

### Remove the Tax Bias

The thrust of the Republican reforms that were vetoed by President Clinton would have been to move decision-making away from Washington. The expected result would have been lower costs and spending. This is the direction in which we need to move and, after the heat of this year's election, we may well do so. There are other potentially helpful reforms, but the only one we will mention is correcting the tax bias.

There is no reason at all why all health care spending should not be on the same tax footing. As we have seen, tax-free, employer-paid health insurance has been a major source of inequity and the heavy reliance on comprehensive "coverage." This bias could be done away with by making employer-paid health insurance taxable to the employee, or by making all health care expenses fully tax deductible for everyone.

Treating health care outlays in the same way as most other items of consumption (with all private health care paid with after-tax dollars) would remove any bias of this reform toward the "rich." If this were done it could be made "revenue neutral" (*i.e.*, not a tax increase) by an appropriate reduction in rates and/or increases in the standard deduction or personal exemption. This bias could be also be avoided if income taxes were completely "flat" on incomes above some basic minimum level. Then health care deductions would have the same effect on everyone paying taxes (presumably, those with no taxable income would be on Medicaid).

It should be noted that either of these changes would be likely to increase the public's interest not only in shopping for the best values in coverage and health care, but also in MSAs and high-deductible (catastrophic) health insurance. As we have seen, they would bring the most powerful force for curtailing costs and spending, consumer choice, to bear on the health care industry. □

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