



GALEN INSTITUTE HEALTH POLICY REPORT

Six Questions Everyone Should Ask About Health System Reform:

An Application of Basic Economics

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Executive Summary

The possible solutions must make the health system stable, efficient, and responsive to consumer demand as well as allocating scarce resources to meet competing wants.

The purpose of this short economic primer is to remind those who assess health system reform proposals that health care is costly and that designing a health system is a complex economic engineering problem. The possible solutions must make the health system stable, efficient, and responsive to consumer demand, as well as allocating scarce resources to meet competing demands.

Six questions are asked to assess the soundness of various health system proposals:

1. How does the proposed system confront scarcity? The current Canadian and British health care systems as well as American private health care are reviewed. No system, public or private, can meet the demands for medical care in the quantities that are generated when patients view it as free or nearly so.

The U.S. system was able to insulate medical care from scarcity until technological progress accelerated in the 1980s and private and Medicare expenditures increased dramatically. To deal with the “health care cost crisis,” Medicare imposed price controls, and employers shifted to various forms of managed care, such as Health Maintenance Organizations (HMOs).

A political backlash against private managed care has precipitated a debate in Congress about whether a law should be passed to assure that “medical necessity” is determined by patients’ physicians rather than their health plans and to give employees the right to sue health plans for harmfully denying medical care.

2. Is the system an equilibrium or disequilibrium system? A health care system that tries to insulate medical care from scarcity will be unstable from both the economic and political standpoints. People will try to subvert the rationing devices that are used in place of market-price adjustment. In contrast, equilibrium systems reach a balance that produces solutions that most can live with.

3. What is the role of prices in the system? The medical care marketplace is a wonderful example of how prices guide resource allocation. However, things have turned out a lot differently than they would have if prices had been allowed to convey incentives for efficiency in traditional ways. Most of our health care problems related to rapid expenditure growth are due to the absence of a proper price system. Because their medical expenses are covered by prepaid benefits, most

consumers are barely aware of the prices of medical care. Consequently, providers have not faced strong pressure to compete on the basis of price and have faced only weak incentives to produce efficiently.

4. Are incentives facing producers and consumers consistent with reform goals? Without cost conscious consumers on the demand side of the market, there will be no incentive for serious market price competition, efficient production, or consumer-oriented service on the supply side. Consequently, providers of services do not face market pressure to compete on the basis of price, but to treat resources as if they were essentially costless.

5. Who determines what health care is produced and who gets it? If our politicians' differences on the approach to determining what gets produced and who gets it persist, we will never solve our health system problems. The mistrust of the market to solve health system problems by many of our politicians is profound, while many others recognize the inability of government to effectively perform the functions that have to be performed if government, rather than the market, is relied upon to run the system.

6. How will they know if it is working? Better feedback systems should be engineered into government-run programs to make information-based corrective action possible before suppliers and consumers are sacrificed to political compromise and bureaucratic inaction. A better alternative, however, is to rely on the market with correctly structured incentives and pricing mechanisms to guide both public and private systems automatically toward their goals.

The major design problem of our current health care system is that people are over-insured. Correcting the incentive to over-insure will go a long way toward solving our health-care expenditure-growth problem. Empowering consumers to take more responsibility for their health care will make prices more meaningful and stimulate competition among providers on the basis of price as well as service. Until consumers confront costs at the point of decision, our health care system will continue to be largely a disequilibrium system. The inability of our health care system to deal with these critical issues will increase the demand for basic change.

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Introduction

It is often said that the United States does not have a health care system. Comparisons are often made between our “non-system” and what many believe to be examples of “real” systems such as the health care system of Canada, where many resource allocation decisions are made deliberately and explicitly by government. Many argue that our non-system should be replaced by a real system where someone is visibly in charge—with authority and power to make it perform in desired ways.

The private U.S. health system is propelled by particular financial arrangements, incentives and price-determination mechanisms that guide the economic decisions of producers and consumers to ultimately determine what the system produces and who gets the output in systematic and highly predictable ways.

In fact, the United States has a bifurcated health sector. About half of the nation’s health care bill is financed through government programs and half through private spending. While the government-run health care programs in the United States operate with many of the policies of rationing and price controls that characterize socialized systems in other developed countries, the U.S. private health sector is a complex, though flawed, market-based system. It is propelled by particular financial arrangements, incentives, and price-determination mechanisms. These mechanisms guide the economic decisions of producers and consumers to ultimately determine what the system produces and who gets the output in systematic and highly predictable ways.

Designing a health system, whether it is run by the government or by individual consumers and producers responding to incentives presented to them in a market, or a blend or combination of the two, is a complex economic engineering problem. It is as demanding of adherence to disciplinary principles as an industrial engineering problem of designing a factory or a civil engineering problem of designing a bridge. If mistakes are made, serious consequences will ensue. As in industrial and civil engineering, a number of basic design principles must be followed in economic engineering to produce a successful product, i.e., an economic system that functions smoothly and maintains itself with a minimum of bureaucratic intervention. The fact that the system will not function in desirable ways unless properly engineered testifies to the fact that it is a real system.

Unfortunately, we are very likely to build serious flaws into our health care system as we redesign it. This is because politics will have a heavy influence in the redesign. Politicians are amateurs at economic engineering. They invariably try to include features that make their constituents think they are being given something for nothing, i.e., that the

government can cause health care goods and services to be available cheaply or for free.

To an economist, fulfilling promises that health care can be produced and distributed without cost is a fundamental fallacy. Therefore, this short economic primer is intended to remind those interested in assessing health system reform proposals of this fact and discusses fundamental economic questions they should ask about the proposals.

These questions address the fundamental facets of the economic engineering problem:

- How to deal with scarcity
- How to make the system responsive to consumer demand
- How to make the system stable
- How to make the system efficient

The health care systems of the modern industrialized countries, including the private and public systems in United States, have not been well engineered from the economic standpoint. Many have priorities other than economic efficiency, stability, and responsiveness to consumer demand. They were created to serve primarily political objectives or to attempt to insulate consumers of medical care from the fact of scarcity. They are in great economic difficulty as a consequence. The systems of Canada and England are used as the main examples.

The system of employment-based health benefits we currently have in the United States arose by accident as a result of an exemption granted to health benefits from World War II price controls. It is now in great economic and political difficulty because of flaws in its design and badly designed attempts to rectify those flaws. Periodically, political momentum builds for health system reform, as it did in 1992 when former President Clinton initiated the debate with a poorly engineered reform proposal. The Clinton plan is used as an example of bad economic engineering in discussing the health system reform questions. As many have said, the Clinton plan would not have worked either functionally or politically.

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targeted pharmaceutical development, and alternative sources of organs for transplantation will rapidly expand the possibilities for spending money on health care. Continued advancement in surgical techniques that began in the 1990s to rapidly reduce the cost to patients of consuming surgery (i.e., the psychic cost—pain, discomfort, and recovery time) will continue to boost demand for procedures. Our current health system's inability to deal with the issues will lead to more demand for basic change.

Many proposals and approaches will be debated from various viewpoints. They will most likely be presented as elaborate legislative proposals to re-engineer the financing and allocation of health care in fundamental ways. The basic economic questions posed below will allow one to assess the soundness of their economic engineering:

- 1. How does the proposed system confront scarcity?**
- 2. Is the system an equilibrium or disequilibrium system?**
- 3. What is the role of prices in the system?**
- 4. Are incentives facing producers and consumers consistent with reform goals?**
- 5. Who determines what health care is produced and who gets it?**
- 6. How will they know if it is working?**

One will note that none of these questions explicitly mentions dealing with the uninsured or medically indigent. This is because engineering a social program to finance their health care is a different problem than designing a system to efficiently serve the vast majority of Americans in the mainstream of economic life. Ideally, a system should be designed to best serve the latter, and subsidize the former so that they can participate in the system as economic equals. Specific approaches to such subsidies are beyond the scope of this monograph.

How does the proposed system confront scarcity?

1

The subject matter of economics as a scientific discipline is resource scarcity and how societies or economic systems allocate scarce resources to meet competing wants. Almost everyone wants more than he or she can afford and every society wants more than it has the resources to produce. Consequently, tradeoffs have to be made regarding what we actually get or produce versus what we want or desire. The discipline of economics is the study of how these tradeoffs are made and the criteria that are used to make them.

All of the financing systems underlying the organized health systems of the world have been designed in a vain attempt to insulate medical care from scarcity. For example:

■ **The current Canadian health care system**, called Medicare, was founded in 1984 by the Canada Health Act that promised to provide all Canadians with publicly funded access to “medically necessary” health services. The Act required each provincial government to provide insured health services “unprecluded or unimpeded by charges or other means, to provide reasonable compensation to physicians and dentists for all insured health services rendered, and to provide payments to hospitals for the cost of insured health services.”

■ **The British National Health Service (NHS)** was established in 1948 based on the principle that everyone in Britain is entitled to almost any kind of required medical treatment, for virtually any condition, free of charge.

■ **The dominant mechanism for financing private health care** in the United States got its start before World War II when some hospitals set up Blue Cross plans to guarantee them a steady cash flow by collecting monthly payments from individuals belonging to employer and other affinity groups. Physicians followed suit by forming Blue Shield plans to collect money to prepay medical care. The hospital and medical care prepayment approach got a big boost during the war when employers were allowed an exemption from wage and price controls to give employees health benefits as well as an exemption of the value of the benefits from employees’ taxable income. This exemption was later codified in the Internal Revenue Code of 1954, solidifying the position of tax-free employer-based prepaid health care as the dominant

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approach in the U.S. These plans promised to pay for all “medically necessary” goods and services. Typically only token cost sharing was required, if any.

Clearly, none of these systems has been able to honor its promises to provide all medically necessary health care free or nearly so. Their experience shows that no system, public or private, can meet the demands for medical care in the quantities that are generated when patients view it as free or nearly so.

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The publicly funded systems in Canada and England are not given enough funding in government budgets to provide the amount of health care demanded by their populations at the prices they set. Consequently, they have instituted various non-price rationing mechanisms such as queuing (i.e., waiting lists for services), de-listing (i.e., removing certain medical products and services from the benefits list) and denying certain high-cost services to elderly patients. Because renewing and upgrading capital reduces the amount of annually budgeted funds available for providing current services, these governments have shut down some hospitals rather than rebuild them when they become old or obsolete. At the same time, they have adopted new technology at a very slow rate, including cost-saving technology which would allow them to substitute outpatient for inpatient facilities that would be more patient friendly, economical and efficient.

The publicly funded systems would be in much more political trouble than they are today if they did not have safety valves to vent off some of the pressure. In England, this is in the form of private insurance that allows people to essentially opt out of the public system and escape the waiting lists and other restrictions imposed by the NHS. In Canada, de-listing services and sending patients to the U.S. for diagnostic tests and surgical procedures have taken some of the pressure off. More and more Canadians have private insurance that funds some of their health care in Canada and in the United States where many spend the winter. The result is that only about \$54 billion of total Canadian health care expenses are paid by government; the other \$24 billion, or 30.6 percent of total Canadian health-care expenditures, is paid by individuals out-of-pocket or through private insurance.

In England private medical treatment may be received in private or NHS facilities and may be delivered by private or NHS physicians. The patient pays the full cost of treatment and facilities to the appropriate parties either out of pocket or through private insurance. It is common for patients to jump queues by invoking private insurance. Many British physicians supplement their incomes through private practice, and private revenue is an important source of supplemental funding for NHS hospitals.

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private and Medicare expenditure growth increased. To deal with the “health care cost crisis,” Medicare imposed price controls, and employers shifted to various forms of managed care, such as Health Maintenance Organizations (HMOs). Price controls are now seriously eroding services provided to Medicare patients in the fee-for-service side of the program, and they are causing many HMOs to withdraw from the program on the managed care side. A political backlash against private managed care has precipitated a debate in Congress about whether a law should be passed to assure that “medical necessity” is determined by patients’ physicians rather than health plans, and to give employees the right to sue health plans for harmfully denying medical care.

Because of the inability of health systems to honor their promises of insulating medical care from scarcity, only a small minority of individuals is satisfied with their health care system. A 1999 international survey by Lou Harris and Associates found that 79 percent, 72 percent, and 79 percent of respondents in Canada, England, and the United States, respectively, thought that their system needed fundamental change or to be completely rebuilt. (Ironically, most Americans also say they are generally satisfied with their own personal health care).

One might think it ironic that despite their feelings that they are deprived of medical care, the beneficiaries of these systems actually consume too much health care when gauged by economic resource allocation criteria. Because of the low out-of-pocket price of employer-provided and publicly-funded care to consumers, they consume much more than they would if they had to make personal trade-off decisions by paying the full resource cost of the care themselves. In principle, the amount that they over-consume could be reallocated to purchase other goods and services that give them more satisfaction. The amount of satisfaction that consumers forego by consuming more than the optimal amount of an individual good is called a “deadweight loss” to the economy. Some economists have estimated that the amount of the deadweight loss of health care to the U.S. economy due to over-insurance is approximately 28 percent of total health care expenditure.

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2 Is the system an equilibrium or a disequilibrium system?

An equilibrium system is most often illustrated in economics by the model of market price adjustment to equilibrate supply and demand. If the market price is too high, there is more of a commodity or service for sale than people want to buy (i.e., there is a surplus), and there is market pressure on sellers to lower the price. On the other hand, if the market price is too low, people want to buy more of the commodity or service than sellers have to sell (i.e., there is a shortage), and sellers have the opportunity to raise their prices. Prices adjust to shortages and surpluses until people in the market want to buy the same quantities as sellers have to sell; then the market is in equilibrium. The price that produces market equilibrium is called the market-clearing price.

If prices do not adjust to clear the market, the market will remain in a state of disequilibrium. Some will no doubt remember the lines that formed at gasoline stations in the United States during the Arab oil embargo of the late 1970s. Price controls imposed by the federal government on gasoline prevented the price from rising to clear the market. The price of gasoline was pegged at around 50 cents per gallon, but buyers couldn't get all they wanted to buy at that price. Many operators would sell only five gallons to a customer at a time. Many others simply sold all their stock and closed their stations until they received their next delivery. The market remained in disequilibrium until foreign supplies began flowing into the country again and the government removed the price controls.

Most consumers would have preferred the price to rise to a market-clearing level so that the gasoline they needed would be available. After all, not being able to buy gasoline at a low price is the same as not being able to buy (i.e., "afford") gasoline at a higher price: you don't get the gasoline. However, consumers would have had the option of giving up something else they might buy to spend the money on gasoline if they really want it.

In the previous discussion of scarcity, it was noted how health systems built on promises to provide all medically necessary health care free of charge, or nearly so, could not achieve their objectives. They cannot produce all the services that populations demand at the low or zero

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prices that are charged for the services. The systems are characterized by perpetual shortages that must be dealt with in less than straightforward ways.

A health care system that tries to insulate medical care from scarcity will be unstable from both the economic and political standpoints. Economically, people will try to subvert the non-price rationing devices that must be implemented in place of market-price adjustment. For example, they will take advantage of opportunities to opt out of the system, bribe their way to the head of waiting lists, or go abroad for health care. People will be complaining constantly that promises are not fulfilled, inconsistencies are infuriating them, and they are denied their rights.

Politicians will seize on these complaints to agitate for changes to the system. The faults of the system will be the constant subject of political debate and commission studies and reports. Politicians and governments rise and fall because of the instability created by disequilibrium health care systems that cannot possibly fulfill their promises. For example, the current debate raging in England about the National Health Service is focusing on the competency of Prime Minister Tony Blair and his Labor government to keep its election campaign promises to reduce waiting lists for surgeries. Blair has been forced to declare that health care is his party's top priority when no previous government has been able to make progress toward improving its performance. He has also been forced to promise substantial increases in funding for the NHS even though he probably cannot raise taxes to pay for it.

In contrast, equilibrium systems reach a balance that has some theoretical optimum properties but from a practical standpoint produce solutions that most can live with. Although no Utopian solution is available to us because of the economic scarcity problem, an equilibrium system is likely to provide a permanent solution to our health-care problems. A disequilibrium system will produce perpetual health-care problems.

A good example of how our system retards convergence to equilibrium is its response to the recent introduction of the drug Viagra for treatment of erectile dysfunction (ED) in April of 1998. Faced with a

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potential out-of-pocket cost of zero or a small fraction of the \$10 per pill price tag faced by third party payers as well as the fact that Viagra considerably reduced the non-pecuniary cost of treating ED compared to alternatives previously available, consumers clamored for access to the drug in unexpected droves. The initial reaction by some payers was to refuse coverage by classifying the drug as a lifestyle enhancement rather than a medically necessary treatment. Some simply refused coverage on the basis of projected cost, while others established monthly quotas for which they would pay, such as six or eight pills per month. Although the federal government initially ordered (and later withdrew) a directive for the Medicaid programs to cover Viagra, several states continued to refuse coverage, while others implemented restrictions on coverage.

The U.S. response to the high demand for Viagra is illustrative of how Canada and European countries with government-financed health care systems have tried to limit expenditures on pharmaceuticals for years. In addition to limiting the prices they will pay for drugs through price controls, which discourage some companies from trying to introduce new drugs into European markets, common practices include delaying the approval of new drugs, placing tight restrictions on eligibility for prescriptions of selected drugs, and limiting availability of some drugs to patients. For example, approval of drugs in Norway, Belgium, and Germany lags two years behind approval in the United States. Certain cancer drugs can only be obtained through university hospitals in England, where the 5-year survival rate was shown to be 66.7 percent compared to more than 80 percent in Sweden and France and an overall average of 72.5 percent in Europe. A number of revolutionary new anticancer drugs are expected to be available just as the incidence of cancer begins to rise among Europe's aging populations, but many expect that health officials will keep them off of approved formularies for cost reasons.

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Even most so-called market-oriented health care reform proposals overlook the issue of equilibrium. The basic problem is the nature of the health plan concept they incorporate in their design. For example, a once popular "market-based" proposal was "managed competition" which envisions competition among standard prepaid health plans supervised by a government agency. The problem is that standard prepaid health plans give enrollees a sense of entitlement to services; in exchange for paying the plan's premium, they are promised all medically necessary health care, most often at token rates of cost-sharing. Prepaid plans must still ration because the total demand of the enrollees for medical goods and services can easily exceed the amount that a plan can provide at competitive premium rates.

One approach that recognizes the equilibrium issue to some degree is the Medical Savings Account (MSA) plan that combines a cat-

astrophic insurance policy with a tax-free cash account for paying the first few hundred or thousand dollars of medical expenses that an individual or family incurs in a given year. As long as medical bills are paid from the cash account individually at the point of service, the consumer is aware of the actual cost of each service and makes each purchase decision accordingly. An incentive for the consumer to consider the necessity and worth of each purchase relative to alternative uses of the fund (i.e., the “opportunity cost”) is provided by the fact that unspent balances in the MSA can be carried over at year’s end to accumulate in the account. Once the deductible is met and the catastrophic insurance policy begins paying expenses, the consumer may shift perspectives to a sense of entitlement. However, the incident that precipitates the insurance payment will probably be a major episode of illness that is legitimately indemnifiable through insurance.

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The issue of insurance poses a basic dilemma for health system engineers. Since most health care needs are precipitated by the realization of events that are rare but costly, they are natural candidates for insurance. But insurance causes people to act differently than when they are not insured. They may undertake riskier behavior when they know insurance will come to the rescue if they do realize an insured event. And if they realize an insured event, they may adopt a sense of entitlement and demand more than they would if they were paying medical bills out of their own pockets.

Cost-sharing (deductibles and co-payment) is the traditional approach to tempering demand for services covered by insurance, but it can not be completely effective because it does not confront the insured with the full cost of their consumption. Third party oversight of physicians’ treatment recommendations is a newer approach that is not working out very well for a number of reasons, both economic and political. It has been suggested that true indemnity insurance, rather than insurance that promises to pay for all “medically necessary” care that the insured and their physicians decide to consume, would be a better insurance approach to containing demand. Indemnity insurance would pay a specified sum for each insured event and would place the responsibility on the patient for allocating a fixed budget toward dealing with the problem. However, determining the amounts to indemnify for each conceivable event is problematic.

3 What is the role of prices?

On the surface, it may seem that prices have never been very important in our health-care system, which was founded on cost-based reimbursement for hospitals and payment of whatever the doctor charged as long as it was not too much more than the other doctors charged. In fact, prepayment only masked the working of the market.

Prices are a fundamental component of a market adjustment mechanism that guides resource allocation toward equilibrium. In the short run, prices rise and fall to indicate shortages and surpluses, giving resource owners signals indicating where resource investments should be made, increased, or decreased.

In the 1970s gasoline shortage discussed previously, it was noted that the problem was not resolved until the embargo was lifted and petroleum imports were restored. Had prices been allowed to rise, domestic producers would have quickly increased production, and the shortage would have been over much sooner. The higher prices would have made it profitable to uncap existing wells that had been shut down because crude prices had fallen below the domestic cost of production when imports rose previously. Domestic exploration and development would have again become profitable, and new wells would have been brought in to increase domestic production. But, political considerations and a mistrust of the market never allowed this to happen.

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Prices have had profound effects on the evolution of our health care system:

- **Hospitals and physicians were not rewarded for producing products more efficiently** (at less cost) than their competitors. Non-price competition among hospitals led to excessive duplication of facilities and services. Physicians and others were not as frugal or as consumer-oriented as they would have been in a price-competitive market. The cost of medical care was inflated above what it would have been in a competitive market.

- **Rewards for developing and employing new technology were excessive.** Developing cost-saving technology to improve and reduce the cost of existing products was not as lucrative as developing new products that invariably added to expenditures. The medical technology industry flourished and Americans enjoyed rapid medical progress.

■ **Minimal resistance to high drug prices** and high demand for new treatments made successful development and introduction of new drugs highly profitable. The pharmaceutical industry flourished, and Americans enjoyed rapid progress in pharmaceutical development.

■ **Because health care appears to be almost free**, many people believe they can have their cake and eat it too. They expect rapid development of “silver bullets” that will cure the consequences of persistent bad habits such as smoking and drinking, bad diets and sedentary life styles, as well as faulty genes.

The medical care marketplace is a wonderful example of how prices guide resource allocation. However, things have turned out a lot differently than they would have if prices had been allowed to convey incentives for efficiency in traditional ways. Most of our health care problems related to rapid expenditure growth are due to the absence of a proper price system. Because their medical expenses are covered by prepaid benefits, most consumers are barely aware of the prices of medical care. Consequently, providers have not faced strong pressure to compete on the basis of price and have faced only weak incentives to produce efficiently.

It would be relatively easy to make prices more relevant to consumers and producers so that competition could improve the economic efficiency in our current system. Some of the market-oriented reform proposals recognize this.

■ **The first \$1,000 of the almost \$5,000 per employee** that U.S. employers pay on average for health benefits goes to the administrative cost of processing and paying small medical bills through insurance carriers providing administrative services. If people paid these bills out of pocket, they would save that money and have more to spend on actual medical care or something else they wanted more. For example, Medical Savings Account plans are a way to achieve these savings and reward the individual for making the market mechanism work.

■ **Medicare’s price controls for hospitals and physicians** do not foster competition among these providers that would otherwise increase their efficiency and improve their consumer orientation. Medicare could convert its physician payment systems into a competitive system by letting physicians determine their own conversion factors (the multiplier that converts the relative values of the individual service

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es that Medicare pays for into dollars) that they think would be competitive in a consumer-driven market. Medicare could then adjust its own rate of payment at a level high enough to give beneficiaries access to a certain proportion of physicians in each market at no out of pocket cost. Physicians would compete with each other on the basis of price as well as service to consumers. A similar system could be implemented for Medicare's hospital payment system.

■ **Medicare's antiquated cost sharing requirements** compel a large majority of beneficiaries to obtain private supplemental insurance (63.6 percent of beneficiaries are covered by private supplemental insurance; another 26.4 percent are enrolled in Medicare HMOs or Medicaid). Supplemental insurance, which is purchased by beneficiaries from private insurance companies or is provided to them by their former employers as a retirement benefit, converts Medicare into first dollar coverage. The extra demands that first dollar coverage stimulates costs Medicare about a third more than would be spent otherwise, according to the U.S. Physician Payment Review Commission. Medicare could save itself money and spare beneficiaries and their former employers the necessity of insuring against Medicare's excessive cost-sharing requirements by folding all of its cost sharing into a single, modest deductible low enough to discourage beneficiaries from insuring against it but large enough to represent meaningful cost sharing. Since 80 percent of beneficiaries annually are liable for cost sharing of less than \$1,000, a reasonable deductible might be \$500 compared to the average \$1,200 annual cost of a private supplemental policy.

Are incentives consistent with reform goals?

4

The goals of past health system reform proposals have been wide-ranging, directed at achieving cost containment, quality improvement, consumer choice, economic efficiency and expanded access to medical care. If one examines the incentives presented to consumers and producers in these proposals, one must conclude that none of these objectives could have been achieved. Rather than relying on incentives to drive consumers and producers toward these objectives, most proposals have relied on regulations to counteract the incentives built into the economic structures that the proposals would have set up.

In our present system, insured consumers face prices that indicate to them that health care is free or nearly so. They are insulated from the cost of consuming services by prepayment and do not have incentives to be aware of the cost of resources they consume and to weigh the cost of alternatives in making decisions. Consequently, providers of services do not face market pressure to compete on the basis of price, but to treat resources as if they were essentially costless.

To counteract these perverse incentives that drive up the cost of providing health benefits, employers have almost universally hired third parties to “manage” their employees’ consumption of medical care by intruding into the physician-patient relationship. This intrusion has precipitated a consumer and legislative backlash against managed care. Perhaps this will result in some modification of the managed care approach, but the incentives that guide consumer and provider behavior will still be intact.

The government has resorted to price controls to control the cost of its health benefit program for the aged and disabled (Medicare). Price controls do not serve the consumer’s interest any more than managed care does. Studies by the American Medical Association and the Medicare Payment Advisory Commission have discovered that physicians are responding to Medicare’s price control cost squeeze in ways economists have predicted they would by:

- Reducing the time spent with each patient, and increasing the number of patients seen per day

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- Treating only one medical problem per patient visit
- Reducing amenities such as educational materials, counseling, returning telephone calls, and arranging for social services for patients
- Reducing practice cost by performing procedures in hospitals that were formerly done in the office
- Delaying or canceling upgrading or purchasing new equipment, especially new technology

A basic problem in engineering economic incentives is how to reward physicians so they will be ideal agents for their patients. Patients hire physicians as their agents to act on their behalf in providing information, aiding them to make decisions about their medical care and securing entry into the medical care system. Agents are expected to make exactly the same decisions that patients would—if they possessed the necessary information to make highly technical, informed decisions. The agent should not serve more than one master (the patient). Clearly, the agent principle is violated by managed care as well as Medicare price controls. This is because the missing ingredients are the patients' responsibility for the cost of their decisions and the freedom of physicians from conflicting incentives. Until responsibility for the cost of medical decisions is borne by the individual consumer, we cannot have the ideal patient-physician or agency relationship in medical care. This is because he who pays the piper will always call the tune. In the present world of employer-provided health benefits and managed care, employers and third parties, rather than patients, pay the piper.

With the emphasis of health care reform on cost containment and efficiency, we have to ask if the incentives of any proposed system are designed to foster cost consciousness and economically efficient choice at the level of the individual decision maker—the provider and the consumer—at the point of decision. It is not likely that preserving the present system of incentives by enrolling more consumers in prepaid health plans, where their perceived marginal cost of consumption is significantly below resource cost, will improve incentives on the demand side of the market. Without cost conscious consumers on the demand side of the market, there will be no incentive for serious market price competition, efficient production, or consumer-oriented service on the supply side.

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Who determines what health care is produced and who gets it?

5

Publicly funded health care systems usually have different goals than privately funded systems do. In public systems with fixed budgets, governments try to set priorities for what health care gets produced and who gets it. For example, the state of Oregon tries to allocate its Medicaid spending according to a set of treatment priorities ranked by experts in the order of their medical necessity and the social payoff to treating each condition or disease.

Presuming that maximizing some measure of the population's "health" is the ultimate objective of the British National Health Service, health economists in England spend a lot of their time developing criteria for the government to use in allocating the national health budget. The latest concept being widely discussed is "quality-adjusted life-years" (QALYs), which advocates hope may someday be perfected so that the government can achieve its ideal results. If the contribution of each health service to improving patients' quality of life and longevity can be measured, then in principle the budget could be allocated to provide services in the quantities necessary to maximize the total QALYs enjoyed by the population served by the National Health Service with its limited budget. This approach to determining what health care is produced and who gets it elevates the notion of collective, societal welfare above that of the sovereignty of the individual consumer.

Reflecting a different tradition that emphasizes individual rather than social choice, health economists in the United States spend much of their time analyzing the efficiency of how health care is produced and how the same things could be produced at less cost. The presumptions are that consumers and their physicians determine what is produced and are guided by patients' resources and tastes and preferences, their physicians' knowledge and experience, and the incentives facing physicians and patients. An important topic for study by American economists is the physician-patient agent relationship and how incentives affect the physician's impact on patient choices.

Health care is not a be-all and end-all for Americans, but only part of the package of goods and services they choose to consume. Just as

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Americans' management of their diets will never be focused exclusively on optimal nutrition, their choices in health care and other dimensions will never be focused on achieving ideal health. Rather, we pursue a broader objective of enjoying life with a maximum of overall satisfaction. The amount of health care we want depends a great deal on the other goods and services we consume; medical care cannot be considered in isolation from the other aspects of our economic lives. If our government tried to isolate health care and fix the amount of resources that were devoted to it and implement some explicit allocation scheme, it would be a long time, with a high turnover of elected leaders, before Americans would adopt a spirit of sacrificial group deprivation that many in England seem to have done in accepting the type of rationing performed by the British National Health Service.

The designers of the Clinton health system proposal, in an attempt to satisfy all ideological sides of the political debate over health system reform, tried to mix the two incompatible concepts of fixed budgets for health care and individual freedom of choice. The plan incorporated "global" budget ceilings as its approach to cost containment, while managed competition between health plans catering to individual preferences was supposed to provide the freedom of choice that Americans want. In this way, the Clinton proposal tried to blend the two approaches to determining what is produced and who gets it, i.e., social and individual choice. But, by imposing expenditure ceilings on the framework of managed competition, the plan essentially negated the role of prices in determining quantities of services to be produced, which would have severely restricted the role of individual preferences and choice. Much of the basic criticism of the Clinton plan was precipitated by its attempt to interject too much government intrusion into determining how much and what kind of health care Americans would have received.

If our politicians' differences on the approach to determining what gets produced and who gets it persist, we will never solve our health system problems. The mistrust of the market to solve health system problems held by many of our politicians is profound, while many others recognize the inability of government to effectively perform the functions that have to be performed if government, rather than the market, is relied upon to run the system. The problem of substituting centralized management for market mechanisms will be examined in the next section.

How will they know if it's working?

6

Had the Clinton health system reform proposal been enacted, the government would now perform many more functions of our health system. Among them are:

- Monitor, set, or negotiate prices for physician and hospital services
- Determine the “reasonableness” of drug prices
- Implement and enforce global budgets, i.e., expenditure ceilings
- Monitor quality and manage quality improvement programs
- Collect and provide information to consumers to aid their choosing health plans
- Determine how many specialist and generalist physicians medical schools and residency programs should train

Most of these functions could be performed by price adjustment to competitive forces in a market-based consumer-driven system (global budgets would not be needed to “control” expenditures). In a market system, consumers, rather than government administrators, would be in charge. However, if administrators take responsibility for these functions, they will need to explicitly implement information systems that allow them to attempt to duplicate or improve on the market solution that would otherwise prevail. Presumably, the designers of the Clinton proposal thought they could do a better job than the market by centrally administering most of the functions that the market would take care of automatically. However, history strongly suggests that centrally administered systems produce less desirable outcomes than market-based systems do, despite the best intentions of regulators and bureaucrats.

These are profoundly difficult functions and raise a number of very difficult economic engineering problems. However, the designers of the Clinton proposal seemed to have minimized their complexity and importance because the only measure they proposed to determine if their system was working was to appropriate some funding for studies to evaluate the reform measures and study consumer decision making.

Many of the problems associated with setting up a heavily admin-

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istered system could be simplified if the system sets up and exploits meaningful price-determination mechanisms that respond to surpluses and shortages, changes in demographic and economic conditions both spatially and temporally, and on a local rather than a national or regional level. However, experience indicates that the government is suspicious of price mechanisms and will instead appoint a number of commissions and study groups to assess the performance of the system retrospectively rather than set up real-time feedback mechanisms and automated decision rules where it is feasible, practical, and efficient.

■ **When industry complained** that Medicare budget cuts made by the Balanced Budget Act of 1997 were too severe and resulted in payment rates that were below their costs of production and that many suppliers had been driven to bankruptcy as a result, quick government studies and Office of Management and Budget officials claimed that complaints of economic duress were exaggerated. The fact is that no definitive data were yet available to determine the truth and would not be forthcoming for several more years. In 1999, Congress “gave back” some of the cuts in a political compromise, but really did not know if the giveback was too large or too small.

■ **Two years (1999 and 2000)** into implementation of the new Medicare+ Choice program that changed the payment rates HMOs received for Medicare beneficiaries, HMO plans serving 732,000 beneficiaries had withdrawn from the program. HMOs said that low rates and other burdensome administrative requirements made it no longer profitable to enroll Medicare beneficiaries in particular circumstances. Government studies disputed the industry contention that payment was too low. Beneficiaries, meanwhile, had to scramble to find new sources of medical care as well as money to pay for benefits that many HMOs dropped (primarily drug coverage). Meanwhile in 2000, HMOs reported to the Medicare+ Choice administrators that, collectively, they would drop another 934,000 beneficiaries on January 1, 2001.

■ **Many studies have been produced** on the length and duration of waiting lists for Canadian medical care. Private think tanks and the government come up with different numbers, so it is difficult to say that the facts are really known. Private groups say the evidence shows that the Canadian system is failing to keep up with modern times. Supporters of the government conclude that better administration and management would be the solutions to the problems.

Better feedback systems should be engineered into government-run programs to make information-based corrective action possible before suppliers and consumers are sacrificed to political compromise and bureaucratic inaction. A better alternative, however, is to rely on the market with correctly structured incentives and pricing mechanisms to guide both public and private systems automatically toward their goals.

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Conclusion

By asking some simple questions of those who propose to re-engineer our health care system, individuals can help keep our health system reformers honest about the promises they make. These six questions, enumerated in the body of this booklet, are based on five fundamental economic principles on which every economist agrees:

- Resources are scarce and must be allocated toward competing wants.
- Competing wants must be confronted with limited resources in a way that produces economic and political stability.
- Economic incentives are the fundamental determinants of the behavior of both consumers and producers—not altruism, willingness to share, charitable sensibilities, or instincts to endure deprivation as a group.
- Prices are the major vehicle that motivates resource allocation decisions.
- To be timely and responsive, administrative mechanisms that guide resource allocation must exploit market signals and mimic market-clearing mechanisms as much as possible.

The implications of these principles for engineering health system reform, especially in the light of experience of systems that violate them, are clear.

The major design problem of our current health care system is that people are over-insured. The tax treatment of employer-provided health benefits is the main cause of overinsurance. It provides a means to prepay ordinary, routine, and inexpensive health care with before-tax income. It hides the true cost of health care from consumers, leading to overconsumption and inflated prices. Correcting the incentive to over-insure will go a long way toward solving our health care expenditure growth problem. Replacing the exemption of employer-provided health benefits from employee taxable income with a tax credit would improve the equity of the tax subsidy and allow it to be focused more effectively on lower income Americans.

Medical progress has removed much of the mystery from medical care, and individuals have become more sophisticated in their ability to gather and interpret information about treatment alternatives.

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Empowering consumers to take more responsibility for their health care will make prices more meaningful and stimulate competition among providers on the basis of price as well as service. Until consumers confront costs at the point of decision, our health care system will continue to be largely a disequilibrium system.

Health care cannot be treated in isolation from the rest of the economy and consumer preferences for the entire range of goods and services available to them. Systems that attempt to control cost by establishing global budgets for health services will encounter extreme economic as well as political difficulty. The amount of health care produced in the United States should be determined by the individual choices of all Americans about what health care they want to consume.

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