The Troubled Economics of American Healthcare

Michael D. Reagan, *The Accidental System: Health Care Policy in America*, 1999:

American medical care is often asserted to be the "best in the world." It is certainly the most high tech and can with few exceptions provide more complex, sophisticated treatments than can doctors and hospitals in any other country. In that sense, the "best" claim is supportable. Yet when one considers that 43.4 million Americans lack health insurance despite per capita health care expenditures nearly double those of most other industrialized countries, the claim rings hollow for many. Best for whom? is their question.

Lack of medical insurance coverage is the most widespread "disease" in the United States, one whose origin lies in the inadequacy of the private health care marketplace—in particular Americans' primary reliance on the decisions of private employers to offer, or not, group coverage for their workers. The practice of medicine at the level of the physician or the nurse is a profession, but health care is an industry whose economic characteristics vitally affect the practice of its profession. The coverage shortfall reflects the U.S. refusal to recognize the contradiction implicit in two widely held assertions:

- Everyone should have the best of whatever health care is needed, *but*
- government should keep out of it and market choices (mostly by employers) should determine the availability of coverage.

There, in a nutshell, is the dilemma: how to assure that necessary care is received while treating medical care as one more private good to be bought and sold like cars, or furniture, or financial services—with the difference that those products and services are usually sold on an individual basis, whereas the great bulk of health insurance is purchased by employers to cover a group of employees. (p. 3)

Rick Mayes and Robert A. Berenson, *Medicare Prospective Payment and the Shaping of U.S. Health Care*, 2006:

…as Kenneth Arrow has persuasively argued, we do not want to try to subject health care to the invisible hand of the market. We want physicians and other clinicians to act not as marketplace sellers of services to wary consumers, but as trusted professionals with a duty to serve patients' best interests.

Victor Fuchs, the dean of American health economists, made the same point in arguing not only that the conditions for market competition do not exist in health care, but also that—even if the necessary market conditions were present—there is something fundamentally different about health care: "The production function for health is a peculiar one; it usually requires patients and health professionals to work cooperatively rather than as adversarial buyers and sellers. Mutual trust and confidence contribute to the efficiency of production. Thus the model of atomistic competition usually set as the ideal in economics textbooks often is not the right goal for health."

Although Internet access permits some individuals the opportunity to learn about illnesses and the performance of providers at their leisure, persistent information asymmetries between providers and patients continue to make the idea of a well-functioning market in health care unlikely. That is, the patient cannot really be a wise and prudent shopper for services because she is dependent on the vendor—in this case, the physician—for specialized information on which to base decisions that the physician has acquired through many years of training and clinical practice. Moreover, a lot of health care does not take place at anyone's leisure. Rather, health problems may arise at times and under circumstances where individuals must question but ultimately trust the judgments of the professionals they have selected—acting as patients, not consumers.

Surely, health care needs to de-emphasize reliance on often paternalistic physicians oblivious to the particular preferences and needs of the individuals they are caring for. However, this reorientation should promote patients' sharing decision making with professionals, not taking it over altogether. The vision promoted by some market advocates—especially those promoting so-called consumer-directed health care (CDHC), in which patients are empowered to become wary consumers carefully navigating a retail marketplace of health care providers who need to promote their own services through aggressive marketing—is not one we endorse.

Due to the potential high costs associated with a sudden illness and the cumulative high costs of chronic conditions, our society wants the protection that third party insurance provides. Admittedly, broad insurance protection against health care costs creates what economists call "moral hazard," the natural tendency of individuals to spend more of someone else's money than their own. Some would seek to address this by decreasing the essential role of health insurance. New insurance products, built on tax-advantaged medical savings accounts, impose large deductibles and significant co-payments at the point of service to encourage patients to "take more responsibility for their choices." Yet patients, especially older and disabled persons with serious chronic health conditions, are naturally reluctant to give up the economic and psychological security of good health insurance coverage in exchange for more control over how their money is spent. Rather, they want the payers—in this case the Medicare program—and the providers to determine how best to moderate health care cost increases.

Not only, in our judgment, is the public not interested, willing, or able to become the same kind of prudent shoppers for health care services that they are when purchasing cell phones and airline tickets, but the CDHC model will not actually restrain costs very much, because of the uneven distribution of health care spending among the population. Certainly, higher cost sharing might lead a weekend sports enthusiast to defer obtaining a physician-recommended MRI for recurring knee pain, a prototypical example of supposed wasteful health care spending that might be reduced if the person faced the MRI costs directly without health insurance. And health care costs might be reduced somewhat (but so might be the person's physical and emotional well-being). Yet, in health insurance programs both public and private, the most costly 20 percent of patients account for 80 percent of health care spending. Many of the patients who generate high spending have

one or more persistent, advancing chronic conditions and, therefore, have annual costs far in excess of what any insurance plan would impose in out-of-pocket expenses.

Thus, turning patients into price-wary consumers will not save the system much. Studies continue to document the excessive, and probably wasteful, spending associated with the care of patients with multiple chronic conditions and those in their last year of life. Yet insurance products that reasonably provide financial protection—with limits on deductible and annual out-of-pocket spending limits—serve the purpose insurance was designed for, leaving patients cost-unconscious once they reach the deductible or the out-of-pocket spending limit. Although full insurance coverage surely does produce some excessive spending, as noted, for those who most depend on it, insurance protection provides needed comfort. (pp. 135-6)

Paul Starr, *Remedy and Reaction: The Peculiar American Struggle over Health Care Reform*, 2013:

It is not as though knowledge about how to control payment is in short supply; systems of rate regulation and global budgeting have successfully controlled costs in other countries, and rate regulation is popular in the United States. The obstacles to effective cost containment have been political. Despite the Reagan administration's success with prospective hospital payment [in the mid-1980s hospitals began receiving a flat, pre-determined payment based on a Medicare patient's diagnosis], Republicans oppose price and budget regulation on ideological grounds. And because Democrats needed support from physicians, hospitals, pharmaceutical companies, and other health-care interest groups to pass health-care reform, the Affordable Care Act [Obamacare] did not include stronger cost-control measures such as the budget caps in the Clinton plan. The skewed payment scale that overpays procedure-oriented medical specialties was off-limits in the reform debate. In many parts of the country, hospitals and other providers now form overpowering combinations that are driving up costs, but addressing these problems, as Robert Berenson writes, "would have conflicted with the Democratic political narrative that identified the insurance companies as the health-care villains and the providers as the good guys." (p. 264)

Uwe E. Reinhardt, *Priced Out: The Economic and Ethical Costs of American Health Care*, 2019:

As a percentage of GDP [Gross Domestic Product] or per capita income, U.S. health spending is by far the highest in the world, even though the U.S. population is among the youngest among the developed nations. In 2016, total national health spending in the United States amounted to $3.4 trillion, a claim of 18.1 percent of U.S. GDP, which was then $18.5 trillion. That claim is projected to reach 20 percent by 2025. No other nation even comes close to ceding that large a slice of its GDP to its health care sector. (p. 13)

…prices for virtually any health care product or service in the United States tend to be at least twice as high as those for comparable products and services in other countries. (p. 21)

As noted earlier, the health care "tax" system takes a haircut of 18 percent of GDP. It is projected to take 20 percent by 2025. These numbers, however, actually understate the burden of the health care "tax" on American households. Ideally, we should relate total national health spending not to GDP but to total *personal national income*, because all health spending is extracted from the personal national income of private households, not from GDP.

…an 18 percent claim of health care on GDP in 2016 actually represents a 21 percent "tax" on personal income. The projected 20 percent of GDP by 2025 actually represents a 23 percent claim on total personal income in the United States—almost a quarter.

By comparison, total taxes of any type, at all levels of government in the United States, amounted to 26.4 percent of GDP in 2015, or 30 percent of personal income… Therefore, as a tax system, the health system is not quite as burdensome as general government taxation, but it is a close rival in the United States. (pp. 60-1)

Often not appreciated by the public is that roughly half of all U.S. health spending now runs directly through government budgets: Medicare, Medicaid, Tricare for the military, VA care, and public health. Thus, on the financing side, the U.S. health system long ago ceased to be a mainly private system. (p. 63)

Well known to the health policy expert, but perhaps not to the laity, is that in any given year health care spending is concentrated among a few very sick individuals. …[Consider] this phenomenon for the year 2014.

Half the U.S. population did not use much health care at all in 2014. About 90 percent of the population accounted for only 35 percent of all health spending. The most expensive 10 percent of the population accounted for about two-thirds of all health spending, and the most expensive 1 percent for almost 22 percent of all health spending.

This high concentration of health spending among a few individuals is observed for any large group of healthy and sick individuals—for example, employees of large business firms, or large groups of people with mixed health status in any country. Actuaries refer to this as the "80-20" Rule, because typically for any large group of healthy and less healthy people, 20 percent of that group account for roughly 80 percent of that group's health spending. (p. 86)

Marty Makary, *The Price We Pay: What Broke American Health Care—and How to Fix It*, 2019:

Hospital charges are notoriously inflated—and hard to pin to any actual costs. Each insurance company negotiates a different discount, which varies depending on who has the leverage. The result is that insured patients don't pay full price, unless their insurance carrier doesn't have a contract. Then they're "out-of-network" and face whatever the hospital decides to charge. (p. 17)

Half of metastatic breast cancer patients in the United States report being pursued by a collection agency for their medical bills, according to a large study conducted in 41 states. As a cancer surgeon, hearing the details made me sick to my stomach. Is this what the noble profession of cancer care has become? Is this really how our society now treats breast cancer patients at the end of their life?

The game is out of control, and that's yet another reason health care costs so much. Hospitals and insurance companies spend a ton of money playing the game—the staff, the infrastructure, the subcontractors. In addition to the collection side, hospitals and insurers have small armies of business people who negotiate discounts. Doctors and nurses don't see these people. Their offices are off campus, even tucked away in the tallest skyscrapers in some big cities. Some doctors complain about the growth in hospital administration. But hospitals have to hire a lot of business people to participate in the game.

We see the game at work when we see hospital prices rocket up year after year. Consider joint replacement surgery. Medicare pays less than $13,000 for the standard operation, yet one in six U.S. hospitals charge more than $90,000 for it. And the prices go up year after year, even though it's the same people doing the surgery. How does one explain this price variation and these price spikes in just one year?

The game creates a giant middle layer of health care: the repricing industry, dedicated to negotiating bills among three or four parties after care is delivered. As I learned when attending one of their conferences, it has thousands of consultants and vendors, and well-paid middlemen. The bureaucracy on the hospital side is also large. One study found that for every ten doctors, the average U.S. hospital has seven nonclinical full-time-equivalent staff working on billing and insurance functions. Health care has been one of the leading drivers of job growth in the United States, a trend that has made it the leading industry of the U.S. economy. But is this industry of new hires who are "playing the game" generating a product? Is this game making a meaningful contribution to our country's GDP? Or is it a bubble?

Although the game gets scant attention in the news or in health reform debates, it explains many healthcare trends. It's the reason hospitals are on a buying spree, snapping up private practices and other hospitals. It explains insurance company mergers. The players need power when they clash in the markup-discount game. It explains why health care stakeholders spent $514 million lobbying Congress in 2016. They need to keep their footing on the playing field.

These middlemen have nothing to do with removing a tumor, hammering in a hip replacement, sewing a pancreas, or comforting a patient. Yet their will often prevails over the providers of all of these services. This mammoth behind-the-scenes industry has created tens of thousands of millionaires. When people wonder why health care costs so much in the United States, they must remember that the cost of the giant repricing industry is built into the cost of medical services. The question no one in the health care establishment has been asking is: Do we really need it? (pp.28-30)