

Bill Watkins

September 12, 2009

This week and over the coming weeks the media and the nation will once again focus on healthcare. Before we launch into the next phase of the argument, though, we should first dismiss a couple of “Red Herring” claims that we spend too much on health care.

These claims are the ones based on a view of healthcare spending as a percentage of Gross Domestic Product (GDP), or that look at the increase in healthcare spending over time. Proponents say that spending 14 to 17 percent of gross product on health care is evidence that we spend too much. Or, they say that health care spending is increasing at a far faster rate than the economy is growing.

So what?

There is no optimal amount of healthcare as a percentage of GDP. Remember, healthcare is a good thing.

We live far healthier and longer lives today than we did just a few decades ago. The technology is constantly improving, and marginal improvement is expensive. Life expectancy, both at birth and conditional on age, is constantly increasing; our population is getting older. Our income has been increasing, at least it was prior to the recession, and I’m confident that it will eventually resume growing. All this would imply that we would expect to see increasing healthcare spending. As Virgil said, “the greatest wealth is health.”

That is not to say that there is no waste in our healthcare system today. We do way too much diagnostic testing in the United States. Our doctors work in constant fear of lawsuits. Consequently, they order far too many diagnostic tests and procedures. The problem is that in a U.S. court — long after the fact and with years to reflect — any test that would have diagnosed the problem always looks as if it would have been the right thing to do. This is true even if not one in a thousand doctors would have performed the test in the same situation.

In contrast, some countries have special courts for the medical industry. These courts are well-versed in the reasonable procedures and diagnostics that competent, reasonable doctors would perform. Consequently, there are fewer suits, smaller judgments, and less money spent on unnecessary diagnostic tests or procedures. Implementing something like this, or some other tort reform, would lead to potentially huge savings.

In addition, American healthcare is still a paper-based system. Even after just about every other sector has converted to computer-based record-keeping, the medical sector persists in maintaining paper files. There are estimates that as much as a \$300 billion could be saved by digitizing medical records while improving service and health care.

Arthur Laffer, in an August 5, 2009 Wall Street Journal opinion piece, argued that the problem with US healthcare is that the payer of healthcare services and the user are not the same person or entity. He correctly pointed out that this creates a wedge that enables excessive consumption of healthcare. It's as if you had a brother-in-law who eats hamburgers, French fries and sodas when he pays his own dinner bill, but orders prime rib and wine when you purchase his meal. He may also be willing to use a generic drug if he is paying for his medicine, but will insist on a more expensive name-brand if someone else is paying. Laffer argues that a private, low-cost, high deductible, catastrophic insurance program would be more efficient. Basically, he wants to let the markets work.

That's a great idea. But there is no way we will let markets work. Efficient markets would require that we pay for insurance or medical care or go without.

It is not going to happen. As a nation, we're not about to let someone suffer or die because they didn't purchase insurance, or they can't pay the deductible, or they can't afford insurance or medical care.

A market-driven, high-deductible catastrophic plan would work just fine for many people, but it won't work for everyone. Some people just can't afford medical care or insurance, and we have lots of potential ways to help them. A progressive negative income tax could provide a minimal standard of living that included healthcare and an incentive to work, but there are other ways. The government could provide medical care or insurance, or it could simply require that medical providers perform an adequate amount of pro-bono work.

The real problem lies with people who can afford to purchase insurance, but who rationally may choose to be uninsured—call them the intentionally uninsured. A healthy young person could very well elect to be uninsured, even if we were to allow him or her to suffer the consequences of an uninsured accident or disease. Knowing that we are unwilling to let him face those consequences only makes the decision to be uninsured more attractive.

How to deal with this incentive problem? Require medical financial responsibility, even though the approach would face some challenges. The result could be something parallel to the requirements California and other states have for automobile drivers. To qualify for a driver's license, or to register your vehicle, you have to have insurance. Even with these requirements in place, I don't know of anyone who drives without additional insurance protection for encounters with uninsured motorists.

Of course, you don't need a license to live. Knowing that medical treatment is available if needed, many would go uninsured. The question of how we should deal with the intentionally uninsured when they come into the emergency room is a real problem with important implications. These are people who would contribute more than they would consume, and cut the cost to other recipients. It would also increase total spending on health care, as the people would access service more often if they were insured.

But that's OK... health care is a good thing.